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ABSTRACT

The papers in this volume synthesize international disability policies, providing a cross-national perspective on disability definitions, the criteria for entitlement to disability benefits, and measures to facilitate a return to work for disabled individuals. Two papers, which were presented at the International Research Conference on Social Security Disability Programs held April 14-15 1986 make up the bulk of the book. Monroe Berkowitz and David Dean synthesize the common features of eight national disability programs (in Austria, Canada, Finland, the Federal Republic of Germany, Israel, the Netherlands, Sweden, and the United Kingdom) and compare their program administration, criteria for receiving benefits, financing, legal issues, and rehabilitation approaches. Peter Mitchell focuses on the unique objectives of each program, the extent of benefits and services provided, links to vocational rehabilitation, and the range of ancillary services for program beneficiaries, highlighting the policy choices of each nation and their effects on disabled individuals. Appendices contain definitions of disability, a selected bibliography, and a list of publications by the World Rehabilitation Fund. (JDD)

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SOCIAL SECURITY DISABILITY PROGRAMS: AN INTERNATIONAL PERSPECTIVE

Austria, Canada, Finland, Israel, Sweden, Netherlands, Federal Republic of Germany, England

with Analyses by:
Monroe Berkowitz and
David Dean, USA
Peter Mitchell, England

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SOCIAL SECURITY DISABILITY PROGRAMS: AN INTERNATIONAL PERSPECTIVE

Austria, Canada, Finland, Israel, Sweden, the Netherlands, Federal Republic of Germany, England

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The mission of the **International Exchange of Experts and Information in Rehabilitation** is to improve services to disabled persons in the U.S. through augmentation of the knowledge and skills of rehabilitation-related personnel with information from other countries. This project, supported by the National Institute for Disability and Rehabilitation Research, seeks to link U.S. rehabilitation-related personnel with information, persons and programs and policies in other nations with the expectation of enhancing research, education, administrative practices and policies in the United States.

Rehabilitation International, founded in 1922, is a federation of 125 national and international organizations in 80 countries working to improve the lives of people with physical, mental or sensory disabilities. It is an open forum for the exchange of experience and information on research and practice around the world; an active network of more than 1000 disability specialists; an advocate for policies and legislation to address the rights and needs of disabled people; and a deliberative body which maintains professional commissions on the major aspects of the disability prevention and rehabilitation fields.

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Preface

Issues of disability policy related to systems of social security have long been fundamental among the breadth of issues relating to the needs of disabled people with which Rehabilitation International deals. The Rehabilitation International Charter for the 80s promotes examination of all systems of social security to determine that they do not discriminate against people with disabilities and that they increase the incentives for people with disabilities to receive rehabilitation and to function independently.

The RI Charter was incorporated by the United Nations within the UN World Program of Action for the Decade of Disabled Persons, 1983-1992, and once again, issues of income maintenance and social security are regarded as crucial to those measures which will facilitate within society the equalization of opportunities on behalf of persons with disabilities.

For those reasons, Rehabilitation International was especially pleased to have been given the opportunity by the U.S. Social Security Administration to study cross-nationally definitions of disability, criteria for entitlement to disability benefits, and measure to facilitate a return to work for people with disabilities. RI member organizations and associated experts carried out national level research for the study in Austria, Canada, Finland, the Federal Republic of Germany, Israel, the Netherlands, Sweden and the United Kingdom. The International Research Conference on Social Security Disability Programs from which this monograph derives was the culminating action of the RI study.

We are deeply appreciative to the World Rehabilitation Fund for having made possible this publication and the wide dissemination of the findings which will ensue resulting from international collaboration in the analysis of experience so crucial to improving the quality of life for disabled people everywhere in the world.

Susan R. Hammerman
Secretary General
Rehabilitation International

FOREWORD

by Malcolm H. Morrison* **

The papers in this volume provide a unique and far reaching synthesis of international disability policies. Taken together, they demonstrate both the complexity and variability of national disability programs and the major underlying issues which have emerged as important on a cross-national basis.

Peter Mitchell presents a masterly review and analysis of disability programs in eight countries, emphasizing the unique objectives of each program, the extent of benefits and services provided, links to vocational rehabilitation and the range of ancillary services for program beneficiaries. His review identifies both those who receive protection in each nation's program and those who do not. The policy choices of each nation and their effects on individuals who become disabled are highlighted in this comprehensive review.

Monroe Berkowitz focuses on synthesizing the common features of these national disability programs and presents a dynamic and incisive comparison of program administration, criteria for receiving benefits, financing, legal issues, and rehabilitation approaches. Despite significant differences among programs, certain common issues and problems clearly emerge in the comparative analysis.

It is very important to recognize that despite significant differences in the details of national program policies, all disability systems are now faced with a set of key policy issues which no one system has satisfactorily resolved. Yet in every case, each system is trying different policy and program approaches to resolve policy issues and thus this study clearly indicates that disability policy is in a dynamic stage of development on an international basis.

The issues that these countries are facing are focused on the types of programs available, the criteria used to evaluate eligibility, effects of changes in the labor market, and linkages to vocational rehabilitation. In addition, every nation faces the issue of re-evaluating the basic purposes of its disability program in terms of whether the program is continuing to meet the needs of a widening disabled population, including families.

It is now clear that there must be closer linkages between short and long-term disability programs and that more coordination is needed between public and private disability benefits. This type of coordination can lead to reduced disability program expenditures and faster intervention for rehabilitation. In addition, while medical and social criteria continue to substantially affect eligibility for disability benefits, all nations are moving to enhance methods of functional assessment in an effort to more precisely evaluate earning capacity. This also has implications for rehabilitation intervention.

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***The views and opinions expressed are those of the author alone and do not represent the Social Security Administration or the U.S. Department of Health and Human Services.*

All disability programs involve consideration of the labor market factors, especially unemployment rates, availability of jobs, and retirement choices. While there is a great deal of variation in how labor market factors affect eligibility for benefits, most systems have not explicity examined the ways in which labor market changes affect disability programs or the degree to which programs are designed to ameliorate labor market problems. These effects are particularly important when considering increases in disability retirement. But they are also increasingly significant in evaluating whether persons who are disabled can adapt to changing job requirements brought about because of economic adjustments.

No disability program has successfully met the challenge of rehabilitation and return-to-work for those awarded benefits. The criteria for such rehabilitation programs are known but most disability programs have yet to develop comprehensive rehabilitation strategies which link public and private sector service providers with effective referral systems targeting candidates with highest potential who need service intervention. There is evidence that certain countries are experimenting with enhanced rehabilitation approaches; however few nations have as yet developed comprehensive integrated rehabilitation systems.

All of these areas pose challenges to international disability policy and few will be resolved without further examination and thought. At the same time however, most nations are examining issues of program coordination, eligibility criteria, labor market and rehabilitation. And, this review is taking place in the broad context of some questioning of the purposes and scope of national disability policies. This reexamination is leading to a more detailed recognition of the entire population in need of disability benefits and rehabilitation services, the unique requirements of both younger and older disabled and most effective incentives to encourage independence for disabled persons.

This international perspective on disability policy therefore indicates both the substantial development of disability benefit programs and the major challenges which are ahead in meeting the needs of a broader and more diverse population of disabled persons who can benefit from multiple intervention strategies, particularly involving rehabilitation.

OVERVIEW OF INTERNATIONAL RESEARCH PROJECT AND CONFERENCE ON SOCIAL SECURITY DISABILITY PROGRAMS

Approximately 100 invited specialists from ten countries attended the International Research Conference on Social Security Disability Programs, held April 14-16 at the headquarters of the U.S. Social Security Administration. The meeting was organized by Rehabilitation International in cooperation with the U.S. Social Security Administration as the concluding event of a project to examine social security disability programs in Austria, Canada, Federal Republic of Germany, Finland, Israel, Netherlands, Sweden and the United Kingdom.

Representatives of each of the above countries, France, Mexico, the USA and the European Economic Community participated in the three day conference.

On April 14 and 15, the agenda was concentrated on differences and similarities among the eight countries' systems with reference to definition of disability, organization and administration, the adjudication process, blending of medical and vocational assessments of disability claimants, connection of rehabilitation programs to social security disability benefits, and program strategies concerning incentives and disincentives to return to work.

Main speakers were the eight consultants who developed monographs on their national systems: *Mr. Johann Kaiser* of the Austrian Workers Compensation Board, *Ms. Heather Ney* of the Canadian Rehabilitation Council for the Disabled, *Mr. Hubertus Stroebel* of the German Federal Disability Council, *Mr. Risto Seppalainen* of the Finnish Insurance Rehabilitation Agency, *Dr. E. Chigier* of the Israel Rehabilitation Society, *Mr. Tjeerd Hulsman* of the Dutch Joint Medical Service, *Mr. Tor Eriksen* of the Swedish Social Insurance Board and *Mr. Peter Mitchell* of the U.K. Royal Association for Disability and Rehabilitation. Each of the eight addressed several sessions.

Other featured speakers were *Mr. Louis Enoff*, Deputy Commissioner for Programs and Policy of the U.S. Social Security Administration, *Ms. Patricia Owens*, Associate Commissioner for Disability (SSA), and *Mr. Sandy Crank*, Associate Commissioner for Policy (SSA), who provided overviews of current directions of the U.S. system.

Prof. Monroe Berkowitz and *Mr. David Dean* of the Rutgers University Bureau of Economic Research, presented a cross-national overview of problems and trends in social security disability programs.

The subject of defining disability was looked at from three different viewpoints: Prof. Deborah Stone, author of *The Disabled State*, illustrated how a country's history and political policy influence the concept of disability; Prof. Harlan Hahn of the University of southern California, outlined his view that the disabled population is a legitimate minority group and operational definitions should take this factor into account; and Dr. David

Symington of Queens University, Canada, reported on his experiences as a researcher and physician on disability claims cases.

Dr. Erich Mittelsten Sheid, Director of the ERTOMIS Foundation, FRG, gave an audio-visual presentation of case studies of a vocational evaluation system, utilizing medical and vocational information. On April 16, many other vocational experts described new research and programs in the disability field. Mrs. Susan Hammerman, RI Secretary General, spoke on "Social Security: A Critical Policy Issue for Disabled People Worldwide" and closed the meeting on April 16 with suggestions for future research.

DISABILITY SYSTEMS: A CROSS NATIONAL COMPARISON[1]

Monroe Berkowitz and David Dean

INTRODUCTION

To compare the disability insurance systems of eight countries (nine countries if we include the United States which forms the basis of many of our comparisons) seems to be beyond the scope of achievement. The historical, political, economic and social differences seem to make any comparisons meaningless. One could search in vain throughout the world for any replica of the Dutch method of administration through their trade associations. Only in Finland is there a central institute that maintains records on benefits received from both public sector and private sector disability benefit programs. Sweden's single central body administering a complex of workshops is not duplicated elsewhere. Only Israel tests the severity of disability of housewives by having them butter a piece of bread in a test kitchen. The dominant role of a complex of trade associations with hundred year histories is unique to Austria and the Federal Republic of Germany. This list could be greatly extended. As one examines, in detail, the complexities of the structure of disability benefits, the varying methods of assessment of work capacity, the different application and appeals procedures, each country's system is marked by the peculiarities of its value system, its social and political organization and its economic setting and it would seem to make little sense to compare them.

Yet, what emerges as we look at these eight countries—Canada, Great Britain, the Netherlands, Austria, the Federal Republic of Germany, Sweden, Finland and Israel—are surprising commonalities in their disability benefit programs. Of course, if we put each program under glass and examined each detail, we would find striking differences in the way each of these nations goes about transferring cash and providing services to its citizens with disabilities. But, if we stand back and look at the broader landscape, we find striking similarities and, perhaps, most discouraging of all, similar unsolved problems. We begin our comparative look at these countries' programs by taking this broader look at commonalities.

After this introduction, we look at *Administrative Organization*, then something of the *Structure of the Benefit System*, followed by the topic of primary interest, the *Criteria for Benefits*. After that we look at the *Financing of the Program* and the efforts made in *Rehabilitation*. We conclude with a brief listing of the possible *lessons to be learned* from such a cross national comparison.

THE COMMONALITIES

The Diversity of Programs

None of the countries has a single disability benefits program for all persons regardless of income, status or etiology of impairments. On the contrary, each country has several quite distinct and separate programs, varying precisely because of the income and status of the beneficiaries or the cause of disability. In general, each country has the following types of cash benefit disability programs.

1. *A governmental benefits program which rests on some insured basis and is usually restricted to persons with some labor force attachment and their dependents.* There may be more than one such program, or a single program might combine a basic benefit and a supplementary benefit. This is the program(s) which corresponds most closely to the U.S. Social Security Disability Benefits (DI) program and we will concentrate on this program or sets of programs. But there are other programs which exist for of historical reasons, because of the desire to cover special groups or the universal wish to provide some basic floor of financial protection.

2. *A governmental general assistance program which is means tested to some degree.* Benefits from this program tend to be more modest than other programs as they are set at the "safety net" level, below which the particular society deems people should not be allowed to fall.

3. *A governmental disability benefits program for war veterans usually with benefit levels or eligibility requirements more liberal than the programs for the general population.*

4. *A governmental work injury program which pays benefits to those persons who are victims of industrial accidents and diseases.* Historically this is usually the first program established, dating, for example, to the late 1800's in Germany and Austria. But even where the program begins later, as in the United States where these programs began on the state level in 1911, it was the first on the scene, preceding the DI program by nearly a quarter of a century. The most recent trend is to get away from a separate work injury program but usually some vestiges remain—perhaps differential benefits, lower qualifying periods, or separate methods of financing.

5. *Programs for public sector employees which are similar to those for private sector workers but which are separately administered.* In 1983, the U.S. Congress moved to bring federal civilian employees under the old-age provisions of the Social Security Act. The change applies fully only to new employees, but eventually all federal employees will be under the same retirement provisions as private sector employees. The practice of having separate programs for government employees may simply be a vestige of the earlier coverage of governmental employees and as we move towards universal coverage, it may be that the need for separate programs for civil service workers will disappear.

6. *Some system of essentially private sector programs which usually supplement in some way the public program benefits.* In most of these countries, the programs are the result of collective bargaining between the labor movement and trade associations or they may be provided on an

individual employer basis. Protection against disability becomes an important "fringe benefit" for employees in the private sector in the United States where the prevailing ethos encourages private provision of these benefits. But even in countries where the responsibility for provision of these services has been accepted by the government, supplementation from private insurance looms large in importance.

The Problem of Coordination of Benefits

The internal relationships among these several programs differ from country to country. They differ in the degree of allowed overlap among program benefits and the attention paid to gaps in the programs. But no country of the eight studied has succeeded in integrating its various programs into a coherent whole. The apparent confusion that exists in the United States with its multiplicity of programs is not totally absent in any of these countries. In Sweden, where cash transfers are administered by one agency for the most part, other disability benefits providing for rehabilitation, labor market and health services are administered by quite separate authorities and the problem of integration is still omnipresent.

In the United States, there is some coordination between the work injury program and the DI program in that federal law provides for an offset if the combined benefit exceeds 80% of the worker's pre-injury wage. But there have been administrative problems which are not easy to solve. Means-tested programs such as the Supplemental Security Income program are integrated in the sense that the amounts paid under these programs are set in accordance with the person's income including any benefits such as those paid by the DI program. Very little attempt is made to offset benefits from the veterans programs where benefits can be conceptualized as rewards for services performed in the armed services and not to be altered by reason of the receipt of other benefits to which the veteran may be entitled. Possibly only in Finland is there an attempt to keep track of all benefits in a central statistical office, but even here some private insurance benefits may not be included.

Multi-faceted Approach to Disability Issues

More than cash benefits are involved. Each of the countries mounts a multi-pronged attack on the problems of disability utilizing somewhat the same array of weapons. These are cash benefit programs, rehabilitation programs, direct service benefits or allowances such as those for attendant care or mobility allowances, employment creation tactics which vary from sheltered workshops to quota and subsidy systems, and general policies which may have the weight of law on such subjects as access for the handicapped or the promotion of equal employment opportunities.

It is possible to classify these programs and policies in various ways. The cash benefit programs are designed to provide income maintenance or income support and to help alleviate, ameliorate or compensate for the problem. Other programs such as the rehabilitation programs are designed to prevent disability and to restore persons to the work force[2].

Cash benefit and direct services may be close substitutes. Many of these countries provide mobility allowances for those persons who are unable to walk or unable to use common modes of transportation. Such an allowance may take the form of cash payment, a voucher for services, or the provision of loans for an automobile. In similar fashion, those in need of attendant care or housing are often provided with cash payments or these services in kind.

These are important issues for the disabled population. Obviously they address such fundamental matters as who controls the disposition of income as well as who controls the hiring and supervision of personal care attendants. A word of caution may be in order. It will not do to conclude that a particular program does or does not provide for a particular service until one examines the provisions of the law and the level of cash benefits provided. One may substitute for the other.

The Recency of Disability Legislation

In most of these countries, disability benefits legislation tends to be a relatively recent addition to the panoply of benefit programs. Work injury programs constitute the exception since their origins can be traced to the pioneering legislation in Germany at the end of the 19th century. But, in general, the basic invalidity program providing cash benefits on a permanent basis is a relative late comer to the social legislation field. Before 1970, no universal pension system for people with disabilities existed in the United Kingdom. Sweden's program is older but substantial changes were made during the 1970's. It was not until 1976 that the Netherlands covered the self-employed and those disabled early in life. In Israel, the disability program began paying benefits only in 1974.

As with any new program, benefits in the first few years tend to be modest, but disability expenditures tend to grow rapidly as awareness of the benefits increases and eventually governments tend to utilize them as some partial solution to labor market problems. During the expansive days of the 1960's, growth in disability expenditures and other social welfare expenditures was taken for granted, but, as the economic picture darkened, greater attention was paid to these expenditures. Questions arose as to whether the administration of these programs was too liberal or the definitions and tests of disability too lax.

The Slowing Down of Disability Expenditures

In recent years, disability expenditures have tended to slow down. The growth in the number of persons being added to the rolls has also slowed down[3] Although the situation differs, country to country, the slowdown seems to be attributable less to demographic changes than to changes in the benefit structure or administrative changes designed to tighten procedures. Both the rise and the slow-down of disability expenditures seem to be unrelated to any changes in impairment rates.

The Ambiguities of the Disability Test

Each of the social insurance programs poses its own administrative complexities. But whatever the administrative problems involved in death, old age, or unemployment benefit programs, they pale by comparison with the problem of determining who is and who is not eligible to receive a disability benefit.

In each of the countries, benefits are available to a person who is covered by the program and who meets the basic eligibility conditions, which may be a specified number of years of contributions to the program. To collect benefits, the applicant must show that he or she has a medically definable condition of a particular severity and with a particular expected duration. Usually that is not enough. The applicant must also show that the medically defined condition constitutes a labor market impediment in some fashion.

As we will see when we examine this problem in detail, countries differ regarding the mix and balancing of these elements which enter into the disability decision. In general, the problems of assessing the medical impairment is left to physicians with varying degrees of oversight and the vocational assessments are in the hands of persons specially trained for this task. The assessment problems also depend very much on whether the agency is familiar with the case. If the employee already has been assessed and found entitled to the sickness benefit, the situation will be quite different from the situation where the long-term disability assessor is seeing the applicant for the first time. In general, in most countries, there will be some face-to-face contact with the applicant at some time during the application process.

The administrative techniques do not seem to account for the differences among the countries in how they make these disability decisions. The overriding consideration appears to be the condition of the labor market and the policies adopted by each country as to the extent to which the disability program will or will not be used as an early retirement program.

THE ADMINISTRATIVE ORGANIZATION

For the most part, the payment of disability benefits is a social insurance function. By definition, this involves an element of compulsory participation in the system and a measure of government control and operation. As a first attempt to gain some understanding of eight different systems, each with incredibly complicated differences in organization, structure and methods of decision making, we can divide the systems into two categories:

1. Primary administration in hands of governmental agencies.
2. Administration shared with trade or industry associations.

Category 1: U.S., Sweden, Israel, the U.K. and Canada

Those familiar with the *United States* system can well appreciate the difficulties involved in explaining any system to persons not intimately acquainted with all the social and political institutions of that nation. How could one easily explain the relationship between the Social Security Administration and the state-based disability determination services? It would be a difficult matter without some knowledge of the political situation in the United States at the time disability insurance came into the law. Rehabilitation was to be an integral part of the new benefit schemes and the adjudications were to be made in the states by the state rehabilitation agencies[4]. But, in spite of the state-based disability determination units, and the powerful influences exerted by the essentially private litigation process, it is fair to say that the United States system is one which is administered by a single central agency with offices throughout the country. In that respect, it fits comfortably into our first category. It is joined in that group by *Sweden*, *Israel*, the *United Kingdom* and *Canada* which have essentially governmentally-administered systems without a great deal of direct participation by private organizations or groups.

In *Sweden*, the disability benefit system is administered centrally by the National Social Insurance Board which is an independent governmental authority under the jurisdiction of the Ministry of Health and Social Welfare. Locally, administration and decision-making is in the hands of 26 regional social insurance offices which are independent corporations with their own financial structures. Even though we put Sweden in the first category, there is something of a quasi-private/quasi-public nature to these offices, each of which is governed by a board whose chair is appointed by Government. These offices are under the supervision of the National Social Insurance Board. An integral part of the administrative structure are the 460 local tax offices.

An essentially central governmental administration is found in *Israel* where the National Insurance Institute located in Jerusalem carries on its work through 17 branches located throughout the country. Several of these branches have sub-branches. In all, there are some 30 branches and sub-branches which have a disability unit which can handle applications, referrals for rehabilitation and other disability-related matters.

In the *United Kingdom*, it is the Department of Health and Social Services (DHSS) which administers the program through local offices in England, Scotland and Wales. (An identical program is administered by the DHSS in Northern Ireland). A national office handles the data on contributions and regional offices conduct medical reviews.

In *Canada*, the rule of central administration by government applies with the exception of the separate program in the Province of Quebec. Under the Canadian Pension Plan (CPP) there are local, regional but not provincial offices. Information is available at the local offices including the income-security programs offices of the Department of National Health and Welfare, regional offices and client service centers. In certain regions, Canada is sparsely settled and to accommodate persons in these thinly settled regions, there are itinerant offices where forms will be made available and a service officer will assist claimants with their applications.

Category 2: Germany, Austria, The Netherlands, Finland

In the second category, administrative structures tend to be more complex. The *German* health insurance system starts off with administration and financing by local employer-employee organizations (krankenkassen) with some element of governmental supervision, oversight or control. Their pioneering workers' compensation system followed the same pattern and since the work injury and health programs are so intimately tied in with the disability programs, it is natural that administration should have developed along similar lines. At the federal level are separate organizations (institutes) for salaried employees, miners, maritime workers and railway workers. The basic programs for wage earners are administered by some 18 regional or ''*land*'' institutes, a greater number than the present-day number of ''*lander*'', thus reflecting divisions of an earlier time.

Bolderson writing in 1977 about the German system, found 7 different societies/funds, 370 general funds organized on a local regional basis, 921 occupational funds, 161 craftsmen funds, 19 agricultural funds, 15 ''ersatz'' or alternative funds, in addition to the special funds for the miners and the seamen[5]. These funds differ, not only in membership, but in the proportion in which the insured and the employers are represented on their councils and boards of directors. Representatives of both sides are elected to the council by postal ballot which evoke relatively low response, 30 to 40% The boards of directors are chosen from among the council members and it is the council which decides on contributions and on the level of benefits beyond those provided by statute.

Government has a great influence over these funds but plays no direct part in their administration. It financially guarantees the local funds and regional and federal insurance officers exercise some oversight seeing to it that the societies properly exercise their duties according to law. In addition, the provincial and national associations of insurance funds exercise a supervisory role and are themselves responsible to the Ministry of Labor and Social Affairs. Germany was the pioneer in disability-related social insurance and it is not surprising to see its method of organizing services influencing Austria.

In *Austria*, the disability benefits program is administered by a variety of pension insurance funds or institutes. As in Germany, there are separate institutes for wage earners, salaried employees, miners, railway workers, craftsmen, farmers and public workers. Some 28 independent insurance institutes are linked together in a federation which plays a coordinating role. Administration is in the hands of the employers and employees who elect representatives to the governing bodies of the institutes. In practice, it is the trade unions which act as the employee representatives. A federal ministry has oversight powers since the federal government contributes to the funds from general revenue and acts as guarantor for certain of their obligations.

The Netherlands also has some 25 quasi-private/quasi-public associations made up of employers and employees organized into trade unions who figure in the administration of the disability benefits scheme. Some 17 of these associations have joined together and have entrusted the administration of the benefits schemes to the Joint Administrative Service (JAS). (Our references to the trade associations are meant to include the JAS). Responsibility for benefit decisions rests with the associations but they have agreed to consult the Joint Medical Service (JMS) which recommends decisions to them. For the most part, the JMS recommendations are followed.

Finland is different but belongs in this category because of the variety of administrative mechanisms it uses and the variety of benefits it pays. Its Social Insurance Institute (SII) administers a national disability (invalidity) pension which pays a flat rate benefit. In addition, there are employment earnings-related pension and disability pension plans (EPDP) which are administered by several funds of a quasi-public and quasi-private nature. Separate funds administer programs for wage earners, salaried workers, public workers, employees in short-term employments such as longshore and certain crafts, etc. For the most part, these funds insure liability with private insurance carriers although one of these is an exclusive fund without private insurance participation. The Finnish system is one of the few which uses private insurance in this area. The system is one in which the private type of insurance is designed to play a more important role in the future.

The Finnish SII has 5 regional offices which have oversight over the 206 district offices and 244 local offices. The principal insurance carriers have offices throughout the country; some of the pension funds and foundations are attached to their local firms whereas others are administered through regional and national offices. Government ministries exercise overall supervision and a central statistical institute coordinates benefits to prevent duplication and overlap.

STRUCTURE OF THE BENEFIT PROGRAMS

As noted above, each of the countries has a means-tested benefit program, an insurance program for persons with some measure of labor force attachment, programs for persons with work injuries, as well as special programs possibly for war veterans and civil servants. Organizationally, the countries differ as to the degree by which these programs are coordinated with each other and the degree of private sector involvement, if any. These countries also differ as to the coverage of partial disabilities, as well as the relationship between coverage of short-term disability and eligibility for the longer term basic benefits.

The variety of the ways in which the several types of plans present in each of the countries interrelate are difficult to classify. Sweden is probably the leading example of a country where the administration is centralized in a single governmental agency and where the basic pension and the earnings-related supplements are dealt with as one. Adequacy has obviously been in the forefront of Sweden's goals although recent economic stringencies have forced some cutbacks. Finland, on the other hand, has emphasized participation by private insurers, but with a large degree of government oversight and coordination. In most of the countries the existence of the means-tested safety net, the basic pension of some modest amount and the earnings-related supplement testify to the twin goals of providing some level of adequacy, and, at the same time, assure those who have contributed to the program that they will receive some equitable return on their contributions.

Each of the countries programs bears the mark of its historical origins. The German, Austrian and the Dutch systems testify to the strength of their employer-employee associations and the prominent role they played in the administration of the schemes which preceded the present ones. Over the years of evolution of the system, there has been increasing coordination as exemplified by the development of the Joint Medical Service and the Joint Administrative Service. In Germany and Austria, the traditional separations among the different groups of workers remain very much a part of their disability systems.

In the Netherlands, Germany and Austria, the disability benefits program is closely allied with the sickness insurance and work injuries program. In Great Britain, it is an extension of the general social insurance system which evolved from the Beveridge report. In Israel, Finland Sweden and Canada, the disability insurance program is an offshoot of the old-age benefits program, much as it is in the United States, except that each of these countries has some experience in administering a sickness allowance program. It is difficult to say which orientation has the advantage. The problems of disability determination are certainly more complex than determining eligibility for old-age benefits. It would seem that agencies oriented to problems of determining eligibility for sickness and work injury benefits would do better. But, eligibility criteria are different when it comes to deciding disability claims and no country seems to have the grand solution.

Short-term Benefits

To the observer from the United States which has no national short-term disability coverage, the variety and types of short-term coverage in these other countries present some unusual situations. The administrative challenges are almost as formidable as for long-term disability, although by definition, the stays on the programs are shorter and episodes of illness self-limiting, save for relatively small number of people who eventually transfer to the long-term rolls.

The typical short-term disability case involves a covered worker who becomes ill, who takes off from work, and who receives a sickness benefit, perhaps after a short waiting period. These benefits can be paid for an extended period of time if he remains ill and is unable to carry on the normal duties of his job. After a period, perhaps six months, perhaps one year, the worker who remains unable to work can qualify for the long-term benefits.

But, if that is the typical pattern, there are countless departures from the norm. Perhaps the most liberal sickness benefit plan is in Sweden. The worker needs no medical certification for the first seven days he is absent, and there is no statutory limit as to the number of weeks a worker may receive these benefits. Theoretically, at least, he could stay on the short-term benefit rolls until he transfers to an old-age benefit, but the practicalities of the situation would probably dictate his transfer before that time. The levels of monitoring by the social insurance officials are higher for those on sickness benefits; he may be visited at home by a person from the local social insurance office, or be requested to supply additional medical documentation. At some point, the worker may decide that he is better off on the permanent invalidity program, even though its benefits are not as generous.

None of the other countries has a sickness benefit program of indefinite length. In the Netherlands, a person on sickness benefit can receive up to 80% of his wage for up to one year according to the basic governmental program. Under the collective bargaining agreements which cover most of industry in Netherlands, the employer will supplement that amount up to 100% of salary. In practice, therefore, the sickness benefit plan reimburses the employers for a portion of the continuing wage payments to the worker.

The Netherlands' Joint Medical Service (JMS) which makes the recommendations to the trade associations on long-term benefits fulfills that same function in the sickness benefit program. It administers a rather narrow "own occupation" test which changes as the worker remains on the rolls for an extended period of time.

In the United Kingdom, sickness benefits are one of three types of benefits covered under the contributory insurance schemes which owe their origins to the 1948 Beveridge report. Covered workers become entitled to benefits in the event of the loss of their main income due to unemployment, sickness or industrial injuries. Sickness benefits are paid for a maximum of 28 weeks after which workers might transfer to the invalidity benefits program. Workers who are injured by reason of an industrial accident or illness become entitled to benefits from a separate program which pays benefits for only 26 weeks but at a substantially higher rate than the sickness benefit. Industrially injured workers become entitled to long term disablement benefits if they suffer some permanent impairment or if their period of incapacity lasts beyond the half-year period. Transfer from the sickness benefit to the invalidity program is accomplished by simple medical certification in good part because of the monitoring of the worker while in sickness benefit status.

The receipt of a sickness benefit or temporary industrial injuries allowance for some limited period of time is the general pattern in each of the eight countries under consideration, with wide variations in the length of time the short-term benefit is paid and the auspices under which it is paid. In Austria, the sickness or industrial injury benefits may last as long as 78 weeks, while in Canada, these benefits are akin to the unemployment insurance benefits and last only 15 weeks. The 78 week limit in both Austria and Germany is in the nature of an overall limit which allows the funds to calculate maximum liability—a maximum of 78 weeks are allowed in a three year period.

For our purposes, the length of the period of sickness benefits allowed in a country is less important than the degree of integration between the sickness benefit program and the longer-term invalidity benefit. In Sweden, the same agency is involved in both decisions. In Great Britain, decisions are in the hands of physicians, not specifically selected or trained to certify sick leave benefits, and apparently, their certification suffices for the initial long-term invalidity benefit decision. In Canada, the decision-making authorities appear to be quite separate in the two programs. In Germany and Austria, the decisions are the province of the same administrative associations which usually have jurisdiction over the work injuries benefits as well.

Long-Term Benefits

After a person receives short-term sickness benefits for some period of time, he becomes eligible for the long-term benefits should his incapacity for work persist. In the next section we will be concerned with criteria for collecting these benefits. Here, our concern is with the interrelationships among the several types of benefits, if more than one type exists.

To make our discussion manageable, we will eliminate consideration of work injury, veterans, government employees and road accident programs and concentrate, for the most part, on programs which pay general benefits to the insured population and to persons in need. How do such programs relate to one another and to what extent are they integrated? A look at these issuespermits us to examine the types of benefits and their relationship to past earnings of beneficiaries.

Germany

In the Federal Republic of Germany, strictly speaking, there is no general invalidity benefit. Persons who are insured and who remain chronically ill may transfer from the sickness benefits to what amounts to an early retirement pension. There are two such pension schemes, neither of which require a demonstration of total disability. Under the so-called ''occupational incapacity'' scheme, it is the person's earnings capacity which is evaluated. The term ''earnings capacity'' is interpreted as it is in some U.S. workers' compensation jurisdictions to relate to what a person, given his or her physical or mental impairments, might theoretically be capable of earning in the labor market. If it can be shown that the person's capacity has been reduced by 50% in any occupation which may be suitable for him, he becomes entitled to a pension. As we will note later, this is not a wage loss test; the applicant need not withdraw from the labor market, he must demonstrate the loss in his *earnings capacity* within a certain range of occupations.

Those who are more severely disabled may be eligible for higher benefits from what is literally translated as the ''earnings incapacity'' program. The criteria are different in degree if not in kind. To receive this benefit, a person must effectively withdraw from the labor market although he will still be permitted to earn a fraction (one-eighth) of the average earnings of insured people as these earnings are calculated in the pension formula. Either benefit can be paid indefinitely or for a limited period of time if there is some reason to assume that the incapacity will cease in the foreseeable future.

To qualify for either of these benefits, a person must have worked in covered employment and contributed to the insurance scheme for a period of at least 5 years. The benefit paid is wage related. It depends on the person's wage-history and length of employment, subject to a maximum level. Special provisions are made for persons incapacitated early in their careers. If they have paid insurance contributions for a specified minimum period, they are credited as if they had contributed to the system up until the age 55.

The system is financed on a pay-as-you-go basis with approximately 80% of the funds coming from employee and employer contributions to the insurance funds and the other 20% from general revenues. The governmental contribution is justified, in part, by the "blanketing in" of persons from East Germany and other population subgroups.

The German social insurance system is supplemented by benefits paid through their social assistance system for which eligibility is conditional on a means test.

The United Kingdom

The Austrian system is similar to Germany's. The Canadian system, although it has its own quite distinct features comes the closest to resembling the program in the United States. The British system is quite different. After 28 weeks of sickness benefits, the worker who remains unable to work may become eligible for transfer to the invalidity benefit program which began only in 1971. The benefits are rather low but if the worker is under 60 years of age, he will be eligible for a supplementary allowance which is paid at one of three rates depending upon the age of the recipient. The highest supplement is paid to those under 40, and, as pointed out above, those over 60 receive no supplement. Both the invalidity benefits and the supplementary allowances are paid for out of the basic social insurance contributions. In 1975 a non-contributory invalidity pension plan was introduced to cover housewives and others with insufficient contributions to the basic plan. Among the eight countries, only Israel and Great Britain cover housewives in these non-means tested programs.

In addition,there is a safety net for those whose benefits are insufficient to meet their needs. Prior to 1966, these were national assistance benefits and since then they are called supplementary benefits. (Unfortunately in all countries, there is a confusing similarity of names among these benefit programs). Eligibility for these supplementary benefits is based on an income and asset test and they are designed to bring benefit levels up to a stipulated minimum.

Our interest is in cash transfer programs, but it should be said that these programs are supplemented by a wide range of programs which provide mobility services, attendants, housing, employment aids as well as a variety of other specialized services. These tend to be administered at the local level and vary widely across localities.

The Netherlands

The interrelationships among the several types of programs is different in the Netherlands than it is in the countries discussed thus far. The Dutch take quite seriously the concept of a minimum level of income which constitutes their safety net. The level is tied closely to the legal minimum wage which is adjusted for changes in the price level. At the bottom of the Dutch system is the means-tested social assistance program which is administered by municipal social service officers under the aegis of the Ministry of Social Affairs and Employment. The general assistance program will provide benefits to a disabled person up to a maximum of 70% to 100% of the legal minimum wage.

There are two other programs which pay benefits to disabled persons and both of these are administered by the same trade associations which administer the sickness benefits. The first of these is the General Disablement Benefits Act (GDBA) under which certain benefits-in-kind are provided for young persons without any labor market history on a non-contributory basis, as well as cash benefits to persons in the labor force on a contributory basis. The second program is the Disablement Insurance Act (DIA) which pays wage-related benefits to those who have a record of contributions. Because the GDBA can and is used to supplement the benefits paid under the DIA, or because the tests for disability are the same under both programs, their administration is in the hands of the trade associations and, of course, the Joint Medical Service which makes recommendations to the trade associations as to eligibility. We have in Holland, a three-tier system with a special disability benefits program supplementing the insured contributory program and the general assistance program functioning as a safety net under these.

Sweden

In Sweden disabled persons are eligible for an extensive program of services in kind and they benefit from an active labor market policy which provides jobs in the private and public sector by a wide variety of measures ranging from job subsidies, tax credits and job creation. Our interest here is in the cash benefit transfers.

The disability pension system is closely linked to the old age pensions and as might be expected in Sweden with its active labor market policy, the administration of the disability benefits appear to be closely linked with the state of the labor market, especially for older persons. As in the Netherlands, there is a three-tier system with the basic social assistance payments at the bottom safety net level. But, unlike the situation in many countries such as in the United States where persons might receive benefits from the SSI program if their DI benefits fall below a specified level, in Sweden there is a basic flat-rate pension which, for those with a record of employment, will be supplemented by an earnings-related pension.

The basic pension consists of an amount which is indexed in accordance with changes in the price level. A person who is adjudged to be 100% disabled would receive the full pension which is 96% of the basic amount. (In 1985, the base amount was SEK 21,800 and 96% of this amount was SEK 20, 928. As of January, 1985, 100 SEK (Swedish kroners) equalled $11.11 in US dollars. The base pension in U.S. dollars amounted to $2,422 per year). This single pension which may increase if the spouse is also a pensioner and may be paid at the full, two-thirds or one-half rate depending on the disability assessment. It may also be paid on a temporary basis.

A person who has earned income from employment in excess of the base amount for at least three years is eligible for an earnings-related benefit on top of the basic pension. The amount of the benefit is computed according to so-called "pension points." Pensionable income above the base amount divided by the base amount yields pension points with the maximum being 6.5 as of July, 1985. A person at the high pensionable income level of SEK 163,500 per year would have the maximum pension points and would be eligible for a supplementary pension of SEK 85,020 (60% of the base amount multiplied by the pension points) or a total pension of SEK 105.948 (20,928 basic and 85,020 supplementary or $11,765 per year). His pension replaces about 65% of his pensionable income. That replacement rate is greater for the lower income groups; in fact at the lowest income level—persons earning no more than the basic amount—there is a general supplement which brings the replacement rate up over 100% or 144% at the lowest level.

These relatively generous pensions are usually supplemented by private collectively bargained pensions. The Swedish system is one which pays relatively generous benefits to the lower income persons and, as in the United States, the formula which translates the pensionable income into the pension amount is weighted in favor of lower income groups, obviously with the intent of redistributing income. The flat-rated portion, the basic benefit is indexed and changes with the changing price level and since the entire amount is computed on the basis of the base amount, the benefit levels are responsive to changes in price levels.

Finland

The system in Finland differs because of the prominent role played by private insurers and because of the close integration of the several parts of the system. As in the other countries, there is a means-tested welfare program which provides the basic layer of protection. This program is administered at the local or commune level where hospital and health matters are also looked after. There are some 464 communes in Finland.

Under the Finnish system, the government, through the Social Insurance Institute (SII) administers a basic and supplementary disability insurance benefit. This benefit consists of a flat-rate basic amount and a supplement, the amount of which depends on area of residence, the amount received from other pensions and the number of dependents.

The Finnish system differs from other systems in the way the rest of the pension scheme is structured and managed. In other countries, the various governmental schemes are supplemented by private insurance or group collectively-bargained insurances. In Finland, an extensive system of these employer related plans are administered privately but with some governmental supervision and with a good deal of governmental coordination.

These employment-related schemes began in 1961 and are still evolving. Separate acts and administrations, all coordinated by the Central Pension Security Institute, govern different employees. These separate schemes are known in Finland by their respective acronyms. The TEL covers private sector employees and some self-employed persons. Those persons who work in typically short-term employments such as construction or longshoring are insured by the LEL. Farmers are covered under the MYEL and other self-employed persons under the YEL. Separate schemes cover public sector employees. The LEL insures its liability in an exclusive or monopolistic fund; each of the others depend on coverage by private insurance carriers.

The eventual aim of the system is to pay disability pensions from all the sources, public and private which will equal 60% of average salary, as that term is defined under the law. It is expected that as the system matures, the SII pension will decline in importance and the employment related pensions will take the prominent role.

A worker might be employed in several different industries in the course of his lifetime and may accumulate pension credits with one or more of the administrations. If he should become disabled, he could apply at any one and he will receive credits for all of the time that he worked. The record keeping and the coordination is in the hands of the Central Pension Security Institute whose job it is to also see that benefits do not overlap. It administers a complex set of rules to offset benefits which are greater than predetermined maximums.

Israel

In Israel, the system of general disability benefits is a relatively new one. Payments began on a gradual basis in April, 1974 and are administered by the National Insurance Institute which also administers the basic old-age program. Israel has an extensive system of means-tested welfare programs and union and collectively-bargained plans which supplement the government pensions.

CRITERIA FOR BENEFITS

In each of the countries, the disability evaluation process, once the technical details of coverage and eligibility are out of the way, begins with an assessment of the applicant's medical condition. What the program managers want to know, however, is not the medical condition alone, but, rather, whether that condition can reasonably be said to prevent that person from working.

What to Evaluate in Making Disability Decisions

Obviously, it is not possible to probe each applicant's psyche to determine his exact reason for withdrawal from the labor market. The person himself may not be fully conscious of the exact reasons for his choosing to withdraw. The decision maker has to fall back on a series of alternatives. Essentially this a search for proxies which can be used to assess the person's disability (or handicap if we use the WHO term).

1. *Evaluate the person's medical condition or impairment.*

A physician can examine the applicant, record signs and symptoms and make a diagnosis. The person's medical condition can be classified into one of the categories listed in the International Classification of Diseases. A disability decision might be made based upon that diagnosis alone, in most cases with the additional proviso the person has withdrawn from the labor market.

2. *Evaluate the person's functional limitations (disability in the WHO sense) or his residual functioning capacities.*

Although there is no exact definition of either of these terms that would satisfy everyone, it is useful to think of them as measuring essentially the same phenomenon. Given a particular function—say, lifting—a person who is 80% limited has 20% residual functional capacity. Ideally, we think of these limitations and capacities as those which are related to work, but which are independent of any particular job. It is also possible to evaluate the functional requirements of a particular job and then to test a person for the relevant residual functioning capacities.

As with a person's medical condition or impairments, it is possible to award benefits solely on the basis of the person's residual functioning capacity. In some work injury programs this may be the only test, or at least the crucial test. Payments may be made, even though a person is still working and earning wages, on the theory that if an accident left the person with some functional limitations, on the average, sooner or later, these will interfere with his ability to compete in the labor market.

3. *Evaluate the person's disability or handicap (in the WHO sense)*—his inability to work or perform some social role due to his medical condition or impairment.

It is possible to observe the person's partial or complete withdrawal from the labor market, but that is only half the battle. The crucial question for the disability determination is whether that withdrawal can reasonably be attributed to the medical condition or impairment.

The tests that will be used to answer that question will vary across countries and will change within a country over time. In comparing these countries, we have to be aware of two sets of problems. One has to do with the criteria that are established by statute, by custom or by practice. The criteria will vary from time to time depending on the state of the labor market, economic stringencies, political considerations and a host of other reasons. Different criteria might be established for young than for older workers; for professionals and for blue collar workers, etc.

The Functions of the Several Systems

There are another series of problems which present themselves even if the criteria are established and well-known. How are administrators apprised of the facts in the case and how are the various rules that establish the criteria interpreted and administered? *Who* determines the medical condition? *Who* measures the residual functioning capacity? *Who* decides whether it is reasonable to conclude that a person with a particular medical condition and a particular residual functional capacity should withdraw from the labor market? It is not only a question of *who* does it, but *how* is it done.

In each of these countries, these decisions are the product of at least three groups of persons or three systems, as it were. The first of these is the medical system with physicians conducting examinations and making decisions as to the person's condition or, in some instance going further and making evaluations as the extent of disability. The second is the legal system in which adjudicators find the facts and interpret the law and the rules and regulations. I have no good name for the third set. These are the personnel who may be experts in vocational evaluation, who may be claims adjusters, investigators and other types of lay personnel. For want of a better term, I will call them administrators.

What seems to be true is that medical, legal and administrative functions overlap in each of the countries. The countries differ in the exact role they assign each system and the degree to which the various systems overlap.

To summarize this portion of the discussion, it is possible to think about a determination process which focuses on: 1) the medical condition or impairment, 2) the residual functioning capacity, or 3) the disability, which is the failure to perform in a social role and which, in some sense, is the end result. Each country establishes criteria, if not by statute, then, by practice, which are embodied in some set of rules or customary procedures.

The rules and the criteria are one thing; how they are applied is another. Application involves the medical, legal and for want of a better name, the administrative systems, sometimes in overlapping and intersecting complexities.

Benefits for Disabled Housewives in Israel—an Illustration of the Process of Evaluating Applicants

We begin our illustration of the process by first looking at disability benefits for housewives in Israel. These benefits are available only to women and require no record of contribution to the system. By definition, these persons are outside the labor force and hence are not tested on the basis of wage loss. How does one evaluate the disability of the housewife, i.e. her inability to perform her role, and how does one relate the disability, if it is found, with the medical condition to show that one is the reasonable cause of the other? The short answer is that it can be done if concepts are clarified, criteria specified and a lot of resources devoted to seeking the answers. An issue that surfaces, from time to time, is whether the client should be seen on a face-to-face basis by the adjudicators. In Israel, about 20 housewives are scheduled into an evaluation center each day, having been told to expect to spend the entire day there. There are four evaluation centers in the country, the largest of which is directed by a physiatrist with a staff consisting of a rehabilitation officer, an occupational therapist, a clerical staff of about 12 and some 18 physicians who work on a per session basis.

The applicant is given a general physical examination supplemented by examinations by specialists, if indicated. The evaluation centers are located in or near hospitals and a wide range of special tests are available and will be used if a thorough assessment is not possible with the routine examination. The physicians' examinations are directed toward answering questions about the applicants' physical or mental condition. Does the applicant have coronary artery disease? Does the applicant have a hearing impairment? Does she have emphysema or some pulmonary problem? These are the kinds of questions the physicians are trained to answer and they have the time and resources to do the job. They can observe the applicant for a day or more if necessary, they can consult with physicians trained in the appropriate specialty, and they have recourse to laboratory tests as needed.

But that is simply the necessary first step. Obviously if the findings are totally negative, there is no reason to go further, but if a diagnosis of a disability is made, the next step is a functional assessment made by a rehabilitation officer. The officer will use a modified version of the American Medical Association's *Guides*[8] which specifies the percentage ratings to be attached to particular restrictions of motion and flexion. However imperfect, and however they are able to measure endurance or strength, these are truly measures of functional limitations. They are measures of reaching, bending, lifting, walking, etc. which are independent of any particular job or occupation.

But if one has a measure of medical condition and a measure of functional limitation, there is still the crucial question of the assessment of disability or handicap, i.e. the inability to work. In benefit programs for wage earners, the question arises as to the definition of work. What kind of work? Is it the employee's last job? Is it any suitable job? Or is it simply any job which exists, or, even conceivably, any job, whether it exists or not?

Paradoxically enough, in the case of housewives, most of these questions need not be considered. With no apology and a bit of arbitrariness, the job of a housewife is specified as consisting of certain definite and specified kitchen and cleaning functions. An occupational therapist rates the applicant as she sweeps a floor, washes, irons and folds laundry, prepares a cup of coffee, butters a slice of bread or washes dishes.

The director of the center receives the results of these tests and coordinates the results. In cases of wide discrepancies, the person can be reevaluated. If it is deemed necessary, a home visit may be made by a nurse, a procedure which is always followed if allowances such as attendant care are being requested.

None of these tests is perfect. It is difficult to evaluate how long a person can continue a particular motion even if she can do it during the examination period. Raters will differ in their judgement, although periodic cross-validity checks are made. It is not always easy to assess the degree of motivation that an applicant brings to the kitchen and household tasks—after all, the applicant knows what is at stake. But the procedure clearly illustrates the several stages of evaluation which are probably implicitly present in all evaluations, even those which focus on only one of the elements, be it condition, limitations or actual disability.

In evaluating the Israeli system, several aspects must be kept in mind. It is an expensive system even in a small relatively compact country such as Israel. The costs would obviously be greater in a larger, less densely populated country. The system has all of the advantages and disadvantages of a partial disability system. Applicants are rated on a percentage of total disability scale, but they must meet a 50% threshold before they can qualify for any benefits. The ratings also have the advantage of a degree of finality. No appeals are allowed against the ratings except on procedural grounds.

The Sequential Nature of the Evaluation Process

The essence of the Israeli housewife benefit assessment is the narrow definition of her role—the kitchen and household tasks. But that advantage is lost when the issue is the assessment of disability in a worker. The medical condition must be assessed, and, although it is not usual or perhaps even feasible to devote the amount of medical resources to this task as is the case of the Israeli housewives, some medical condition assessment is made in each of the countries' systems. The extent of time and resources devoted to the second stage, the assessment of functional limitations also exhibits a wide range. The Netherlands which uses the Joint Medical Service (JMS) for the medical functional assessment scales has an elaborate system of conducting these functional assessments. In the final analysis, however the existence of a medical condition and some functional limitations are preliminary to a decision. A finding must be made that these can reasonably be said to interfere with the person's labor market chances.

These sequential steps are well illustrated in the Netherlands. First of all, we have the formal criteria—the tests which must be passed, as it were.

> "Fully or partially disabled is he who, as the consequence of illness or impairment, is entirely or partially incapable of earning from work calculated on the basis of his powers and skills and which, in the light of his education and former profession, he can be expected in all fairness to perform at that place where he last performed said labor or a similar,

> nearby location, such a wage as physically and mentally healthy persons with the same sort and extent of education do earn with this work at such locations."

The criteria are even more complicated because of a further provision which states that if a person is found to be disabled in accordance with the above definition, and if he is found to be incapable of work:

> "calculated on the basis of those powers and skills still present at the time he became insured and which can accordingly be required of him in all fairness to perform..."

he may be entitled to benefits.

The formal criteria and the practice begins with a finding of illness or impairment but the law in the Netherlands does not define these terms, which, by and large, take on the usual meaning of medical conditions found by expert physicians. But if the finding is made and if there has been some interruption in earnings, the finding of a disability still requires some further evidence, which in the Netherlands, revolves in the first instance around some functional limitation measures.

The JMS has developed a fairly elaborate theoretical framework in which the exertion required of a person for activities ranging from maintenance of basal metabolism to work is compared to their capacity for exertion. In practice, the person's so-called "capacity pattern" is measured with reference to 38 different items such as standing, climbing stairs, lifting, and walking. The list also includes environmental factors such as tolerance for cold, heat, vibrations, and noise, and even some social factors such as tolerance for working alone or with others. An employee of the JMS, a national insurance practitioner, who is a physician who devotes his entire time to the disability program, rates the applicant on each of the 38 items using a scale from 0 to 5 for each item. His findings are recorded on a capacity form, on the other side of which he records his description of the applicant and his impressions of such things as his attitude and social presentation.

The process is quite complex. The scale is not a one-dimensional scale. Also rated are the frequency with which a factor occurs and the degree to which it is tolerable. The national insurance practitioner determines these capacities on the basis of the medical information available to him. He can ask the claimant to come for a medical examination which he will perform, he can request information from the record, or he can request a specialist examination.

The national insurance practitioner is a member of a three-person team; the other members are the vocational expert and the legal assessor. It falls to the vocational expert to compare the capacity pattern with the range of jobs the person could reasonably be expected to fill, taking into consideration, as the definitions spell out, the person's former occupation, education, powers and skills and the regional labor market.

The relevant jobs are rated by means of the same 38 point scale as is used to rate the person's limitations. The insurance practitioner and the vocational expert then combine their findings and, in light of the applicant's capacity and the wages paid in jobs in the region which he could perform, they determine the claimant's "residual earning capacity." Again, this is a rather complex concept. It is determined by subtracting what the claimant could earn, given his limitations, from what the normal or representative person of comparable age, skill and education could earn. It is then converted to a percentage to arrive at the so-called "theoretical estimate" of labor disability.

If the percentage of labor disability is between 80 and 100%, the person is adjudged totally disabled and is eligible for the full disability benefit. He would receive no benefits if he were adjudged to be 15% or less labor disabled. However, the Dutch recognize the realities of the labor market and, for this, or possibly other reasons, they disregard the elaborate theoretical estimates of partial disability garnered from the three-person team evaluation of capacity pattern and the job requirements if the person has not returned to a job. In the absence of employment, regardless of the percentage rating, so long as it is greater than the threshold, the person can still be adjudged to be fully disabled.

The Realities of the Labor Market

Theoretically, the person is given an augmented evaluation for a limited period of time during which intensive supervision is to be given. At the end of the period, another evaluation is made to determine whether the failure to find employment is due to the labor disability. If that is the case, the double evaluation continues and the benefits go on. If not, the benefit augmentation ceases.

The Netherlands is an excellent example of how each system is governed by its own rules which are a product of a social and economic policy. The Dutch recognize the conceptual differences among a medical condition, a functional limitation and a disability. They have put into place an elaborate and complex system for assessing medical condition, functional limitations, as well as a method for assessing the requirements of particular jobs in the region. They use a team approach in which a physician, vocational expert and legal assessor collaborate to arrive at a percentage of labor disability. In the end, however, it is as if this whole procedure were ignored since all claimants who are assessed at a level above the threshold percentage who are out of the labor market are assumed to be out because of their medical condition.

The Netherlands experience makes one wary of looking at formal definitions or criteria without a thorough understanding of how these criteria are interpreted and applied in the administration of the program. In each of the countries, the tests sound very much alike beginning with the medical condition and ending with the finding that the person is unable to work due to that medical condition. The differences are in the jobs which are deemed to be suitable and the assumptions which are made as to the nexus between the medical condition and the withdrawal from the labor market.

Disability and Early Retirement

In Sweden, the rules applied in disability determination depend upon the age of the applicant. Reforms introduced in 1970 and 1972 in response to an increase in the unemployment rate reduced the importance of the medical criteria. Persons, originally age 62 and older, and then changed to age 60 in 1976, are able to claim a disability pension if they have been unemployed long enough (21 months) to exhaust their unemployment benefits. These cases, known as "labor market" cases, account for the sharp rise in the number of disability pensioners. The number of disability pensions awarded to men and women aged 60-64 almost doubled between 1970 and 1973.[7]

The Swedish experience illustrates one use of the disability benefit and that is as a "ticket out of the labor force." Because of the "labor market" cases, the relationship between retirement and disability is quite clear in Sweden. In 1976, Sweden introduced a system of partial old age pensions and up until 1981/1982 there was some evidence that partial pensions were providing a significant alternative to full early retirement on a disability pension. The National Social Insurance Board noted a small reduction in the number of disability pensions awarded after 1976. Over the period 1976-1982 more persons aged 60-64 were awarded a partial pension (131,910) than a disability pension (120,497). However, during this period, the number of disability pensions awarded on labor market grounds rose significantly from under 10% of new awards to over 20%. Nevertheless it seems reasonable to argue that in the absence of partial pensions employers would have had to resort to other measures in particular full early retirement, in order to manage reductions in manpower and hence the number of disability pensions awarded might have been even higher.

Up until 1981 partial pension provided about the same level of income replacement as a disability pension. When the partial pension was reduced, the number of applicants decreased and the number of disability pensions increased. The increase in the number of disability pensions in 1984 reflected the deterioration in job prospects for the older worker with almost half those retiring early doing so on labor market grounds. But it also probably reflects the fact that it was financially more advantageous for an individual to opt for a disability pension rather than a partial pension[8].

As referred to earlier, the close relationship between retirement and disability benefit is exemplified in Germany where, strictly speaking, there is no concept of a disability or invalidity benefit. Instead there are provisions for early retirement on a complete or partial basis. But, regardless of how it is conceptualized, the problems of identifying who is eligible appear to be the same as encountered in the disability programs in other countries. A person can receive an "occupational incapacity" type of benefit if he is ill or has some mental or physical impairment and is deemed to have lost more than half his earnings capacity in any suitable occupation. The suitability of an occupation is adjudged in accordance with the claimant's age, education, his last job and the actual existence of the job in the economy which is theoretically open, although no actual vacancies exist.

The German system insofar as this benefit is concerned is truly a measure of earnings capacity in that a person need not demonstrate any actual reduction in earnings. In the other system which has been translated as earnings incapacity, higher levels of benefits are awarded to more seriously impaired persons, although even here complete withdrawal from the labor market is not an absolute prerequisite for drawing benefits•.

The Criteria in Theory and in Practice

All countries follow the same general pattern which has been sketched above. All are concerned with identifying the medical condition and assessing its seriousness at one end of the continuum and evaluating the capability for work at the other. In all countries the evaluation process takes place under statutory definitions, administrative rules and regulations, and overall policies which influence the interpretation of the rules.

Can the evaluation process be done in some reasonably scientific valid manner? The answer is that it probably can if the power structure of a country is willing to devote sufficient time and resources to the tasks. It involves cooperation among physicians, administrators and legal personnel and an appropriate division of labor among them. Physicians who may be expert at diagnosis and classification of diseases may not be the ones to make vocational judgments as to the physical or mental demands of jobs. Vocational experts may know about the requirements and even availability of jobs but know little about how disputes should be settled or statutory provisions interpreted.

The link between the medical condition at one end and the assessment of disability at the other is the functional limitation or the residual functioning capacity and this seems to be the aspect of the disability determination process which is often neglected and probably least understood. The process seems to be most developed in the Netherlands where an elaborate system is in place for assessing functional capacity of applicants and matching these with the requirements of jobs. But the Dutch experience also teaches us that if the overriding policy is to use the system to afford early retirement for those persons who cannot get jobs, then the most elaborate disability determination gives way to this priority. In Sweden the process is made explicit with special rules for older workers. The Swedish experience also illustrates the significance of replacement rates. As the pension rises to replace a greater portion of the pre-disability income, applications will increase.

THE ROLE OF THE LEGAL SYSTEM

In the United States, at times. the legal system seems to dominate the administration of the disability benefits program. Legislative amendments passed at the end of the Carter administration without much discussion or comment, called for a systematic review of cases on the rolls. When the Reagan administration began the review, dropping numerous people from the benefit rolls, the program was besieged with law suits. The hue and cry from the media and from the states caused Congress eventually to pass amendments modifying the criteria for removal from the rolls, slowing down, but not eliminating, the review process[10].

The influence of the legal system is magnified by the custom in the United States of ''class action'' suits where the courts will allow a decision to apply to all members of the class as they define those similarly situated. The emphasis on ''due process'' whereby individual rights are protected constitutionally and the tradition of the contingency fee whereby an applicant can sue without making any legal payments until, and in the event the suit is successful, all contribute to the importance of the legal system in the administration of the U.S. disability benefits program.

Reversal rates by the courts are high in the United States, so much so that proposals are being made that a special court system be established to replace the district courts to hear appeals from disability claims.

The problem extends to other countries as well even though the U.S. seems to be the only country with a tradition of class action suits and a system of contingency fees for lawyers. Israeli administrators complain that no matter how logical their decisions, the persistent applicant can find his way into the system. The problem, in part, is the complex nature of the disability decision. As we have seen, it involves a tenuous tracing of the relationship among the condition, the residual capacity and the resultant disability. It is difficult to explain to an applicant, let alone a jurist, that even though the applicant is medically impaired, and even though he is without work, the medical condition is not the cause of his withdrawal from the labor force. The sympathy of the courts may well lie with the applicant and not with the government and the bureaucrats who are applying what seem to be rather arbitrary criteria to deny a deserving person a modicum of benefits.

If we compare the U.S. and the other eight countries,the percentage of applications awarded are higher in each of the other countries than in the United States, but only Israel has a higher percentage of denials appealed. Information is lacking for five of the eight other countries, but, in 1983, the United States showed a higher percentage of denials appealed than did Austria or Canada. Canada and Finland show a higher percentage of denials reversed than does the United States[11] Too much ought not to be made of these comparisons among countries whose systems and traditions are so different. They serve to illustrate only one thing and that is that the determination of disability status is a contentious matter in other countries besides the United States.

The appeals process differs across countries as can be seen by the tabulation of the answers to the questionnaire[12]. No attempt will be made here to cover the details of the appeals process. We note, however, that each country's system does provide for some sort of appeal from the award decision.

In Austria, the initial decisions are made by the insurance institutions. If there is some disagreement as to the nature and the amount of the award, the controversy is handled in the first instance by special arbitration tri-partite arbitration panels where great weight is usually placed on the medical findings. Appeals from these decisions are to the Vienna Provincial Supreme Court which will normally accept the arbitrators' findings of fact and who will decide the procedural and law issues.

The applicant need not have special legal representation before the arbitration panel but will normally have counsel at the Supreme Court stage. The social insurance institute will be responsible for these legal fees and other costs if the claimant prevails.

Under the Canadian system, decisions can be reconsidered, in the first instance, by staff members who did not participate in the original decision. If the applicant is dissatisfied with the decision, he can have the decision reviewed by a three-member review panel. The agency appoints one member, the applicant the second and the two appointees choose a third impartial person. All of these may be lay persons. The third level of appeal is to the Pensions Appeals Board staffed by judges from the Canadian court system. The client is not reimbursed for expenses at the first level but will be reimbursed, at the second and third levels, for legal fees, travel and lost remuneration.

In Finland, initial decisions are reviewed by boards within the social insurance institution or the separate employer-related schemes. These boards consist of representatives of employees, employers, and representatives from the medical and legal communities. Appeals from these decisions are to the Insurance Court consisting of judges who are expert in social insurance matters. These appeals are free of cost to the appellant.

A great deal of discretion is vested in the physician's decisions under the British system. Appeals are to the Social Security Appeals Tribunal which may grant an application for a hearing but the Commissioner has the discretion to decide the matter on the basis of the written record. Some financial assistance is provided for advice to the applicant but not for legal representation. In practice, few appellants are represented by legal counsel.

In Israel, there are provisions for an internal review of the decision and from there the appeal lies to the regional labor court on matters of law only. After that, the appeal is to the national labor court whose decision is final and binding.

In the Netherlands, provisions are made for a review of a decision by the trade association bodies. Medical findings cannot be challenged. From there, the appeal may be to the Social Insurance Council's complaint commission or to the complaints procedure of the Joint Medical Service. When appeals are made to the Central Appeals Council the applicant may be reimbursed for expenses and indigent applicants may receive funds for legal representation. In 1983, less than 10% of the trade associations' decisions were reversed at the Central Appeals Council step.

In Sweden, social insurance office decisions must first be reconsidered by the local office and then, if the claimant is dissatisfied, he can appeal to one of three regional social insurance courts which are independent of the social insurance system. Appeals from these courts are to the Social Insurance Supreme Court which must grant permission for the appeal. Aid will be provided for indigent claimants.

In West Germany, the agency has provisions for internal reconsideration of decisions. Appeals from there are to the commissions, to the "lander" social courts.and, on questions of law to the Federal Social Court.

In each of the countries, the relevant agency can appeal to the courts if they disagree with a decision made by the lower tribunal.

Although none of the countries has the counterpart of the U.S. practice of contingency fees, as noted above, some of the countries will reimburse claimants for some or all of their expenses if their case prevails. Other countries will cover some or all of the other expenses the claimant may incur in attending hearings and providing evidence. None of these methods probably provides as much incentive for the client to appeal as does a contingency fee system where the client is assured that if the lawyer can be persuaded to take the case, it will cost him nothing if he loses. The counterpart to that, however, is the up to 25% of his recovery which he might lose should he win.

Each of the countries, including the United States, has more or less specialized adjudicators to hear appeals that pass the agency reconsideration level. In Austria, Israel, the Netherlands, Sweden and West Germany, the final appeals rest with some specialized social or labor courts whose jurisdiction is not general but does include other cases in addition to those involving disability decisions. In Canada and Great Britain, the final appeals are to the regular court system.

FINANCING THE SYSTEM

One of the interesting commonalities noted in this cross-national comparison of disability benefit systems was the rapid expansion in programmatic expenditures during the 1970's and the subsequent slowing down of costs observed in the early 1980's. To understand what has occurred to the financial component of the disability benefit programs it is necessary that they be viewed as a component of that country's larger social welfare system. The funding level of any social welfare program depends on two elements: the expenditure mechanism to disburse funds to eligible recipients and the subsequent financing mechanism to raise such revenue from the general populace. These elements are related and any analysis of trends in financing must address the linkages.

The following section will first examine the expenditures on disability pensions across the various countries. This amount is comprised of the number of persons receiving disability pensions in each country and the amount received by each person. The relative size of this population will be put into perspective by drawing comparisons to the number of old-age pension recipients in the countries sampled. The amount of the pension received by eligible disabled persons in the various countries will then be examined. To give some notion of the total expenditure on disability pensions this amount is then presented as a percentage of that country's output.

Of course in one sense this expenditure represents the amount of revenue that must be raised to finance the disability pensions for those eligible for benefits. The expenditure on disability pensions must come from some revenue source—from social insurance contributions by workers, from the tax-paying public, etc. Given this relationship between the disabled and the general population, another approach to examine the disability pension program for each country is to examine the expenditure on a per capita basis. With this information we can then begin to look at the trends in the rate of programmatic growth during the 1970's through the early 1980's.

When attempting to make cross-national comparisons about patterns of financing in any social welfare program it is imperative that there be comparable data. This leads to several caveats. First, as already noted, the survey countries differ as to the administrative structure of the disability program. In the United States, the Social Security Administration, a public federal agency, oversees the program; in Finland the program is privately administered by a consortium of insurance institutes. These contrast markedly with the Netherlands where a quasi-governmental trade association administers some aspects of the program. One result is that there are different pools of eligible beneficiaries in each of the programs.

A second problem is that to make any comparisons about expenditures there must be a common currency for a base year. Given the dramatic currency rate fluctuations in the global economy for the past two decades this will certainly impact on an individual countries' level of disability expenditure when contrasted with the benchmark currency.

A third source of difficulty is that different rates of inflation make many comparisons meaningless. As an example, when Israel experienced an annual inflation rate of 300% this meant that prices doubled every three months. Any expenditures would depend critically on when they were collected.

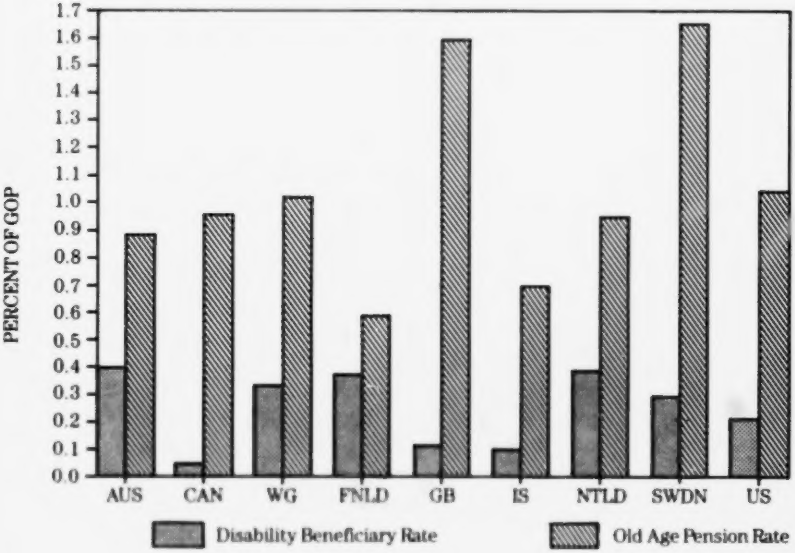
Finally, the data were obtained from the RI correspondents from each of the countries. Where possible these figures were verified and augmented with the use of published data from OECD, UN and ILO publications. After mentioning these potential pitfalls, we will proceed cautiously in trying to discern any trends across the surveyed countries.

To make cross-national disability pension comparisons the first item will be to get some idea of the size of the disability beneficiary population in each of the sample countries. Given the different population sizes, this requires that a rate of comparison be established. *Chart One* presents the number of disability pension recipients per 10,000 persons reported in the general population for 1980. To gain some perspective, the rate of old-age pension recipients per 10,000 persons is also included for the eight survey countries and the United States. Thus in the United States, roughly 1,000 persons of 10,000 (or 10%) in the population were old-age pension recipients while only 200 (or 2%) out of 10,000 were disability pension recipients.

Old-age pension recipient rates range from 600 to more than 1600 per 10,000 population for the eight countries in the study. One explanation for

CHART ONE
DISABILITY BENEFICIARY and OLD-AGE PENSION RATES
(per 10,000 persons)

FOR YEAR 1980
Across All Nine Countries



this range is simply that the old-age pension rate is a function of the demographic characteristics of the particular country. This pension rate reflects the age distribution of the population since all beneficiaries must generally be older than the statutory retirement age and have some work history. If a person meets the criteria, administrators of such programs have little control over the number of recipients.

For the disability pension program a different story emerges. There is a much wider range, in relative terms, in the recipient rate across the survey countries. The rates ranged from roughly 50 to just under 400 per 10,000—a difference of almost one order of magnitude.

One possible explanation is that the lower rates are associated with those countries with the more recently established disability pension legislation. Even if the legislation is well-established, there was often a recent revision. The only exception appears to be the work-injury program which has been in existence for a long period in most of the survey countries. Thus the number of disability pensioners is an artifact of the maturity of the disability pension system. In three countries—Canada, England and Israel—the disability pension recipient rate is on the order of 100 per 10,000, or roughly one percent of the general population. In each of these countries disability pension legislation was only enacted within the past quarter-century. For most of the European countries, which have well-established welfare systems, the disability pension rates range between 300 and 400 persons per 10,000 population.

The disability pension recipient figure is only one component in the determination of the level of country-wide expenditure for such a program. The second necessary element is the *amount* of the disability pension received by the pensioners. To some extent, the percent of the disabled person's "take-home" pay that the pension replaces—or replacement rate—will influence the number of applicants for the programs and possibly the number of recipients.

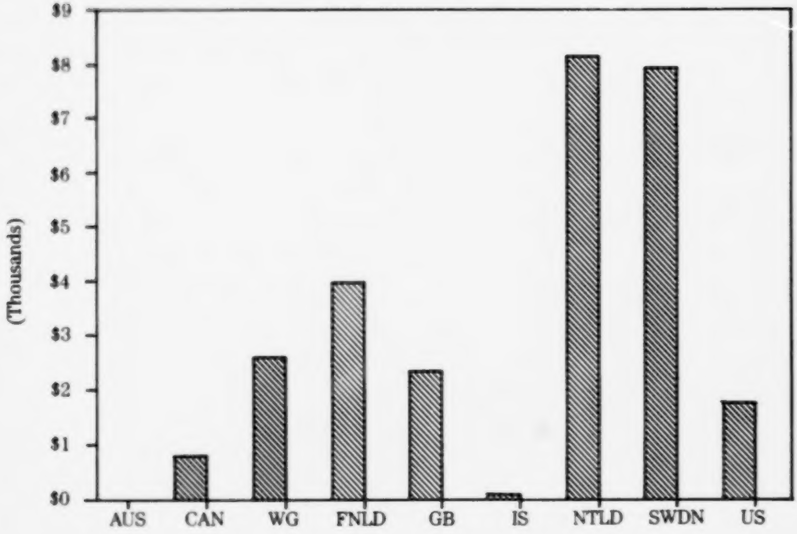
Chart Two presents the average annual amount of a pension received by a disabled person, reported in 1980 U.S. dollars. This figure is obtained by dividing the total disability pension expenditures by the number of eligible beneficiaries. The Netherlands and Sweden have the highest level of pension payments, averaging around $8,000 per disabled recipient per year. Although wage information was beyond the scope of the study, such payments will result in a fairly high replacement rate in these countries. While Finland has the next highest level, at roughly $4,000 per annum, the other countries were significantly lower. England, Canada, West Germany and the United States all averaged less than $3,000 in disability pension payments per annum.

Given the number of disability pension recipients and the amount of pension payments received by these disabled people we can obtain the total amount of disability pension expenditures. Of course any cross-national comparisons about the levels of such expenditure must be weighted accord-

CHART TWO
REAL PER DISABLED BENEFICIARY EXPENDITURES

(in 1980 US $)

Across All Nine Countries



ing to the size of the population.

There are two methods commonly employed to make such comparisons. First would be to take the disability pension expenditure figure as a percent of the value of the output in the country—in this case using Gross Domestic Product (GDP) as that measure. In one sense this percentage figure represents the relative share of the nation's output that must be transferred to eligible disability pension recipients. From Chart Three it can be seen that total disability pension expenditure comprised more than three percent of GDP in Sweden, Finland and the Netherlands. For several of the other countries the rate was significantly smaller—less than one percent of GDP.

Another approach would be to examine the disability pension expenditure on a per capita basis. These figures were obtained by dividing the total disability pension expenditures for each country by the respective size of the general population and then converting this figure into real U.S. 1980 dollars. From *Chart Four* one can note the relatively high expenditure per capita for the Northern European countries. In Finland, Sweden and the Netherlands the per capita amount exceeded $150. This contrasts markedly with the situation in the U.S., Canada and England where the figures were on the

CHART THREE
DISABILITY EXPENDITURES AS A PERCENT

OF GROSS DOMESTIC PRODUCT (FOR 1980)

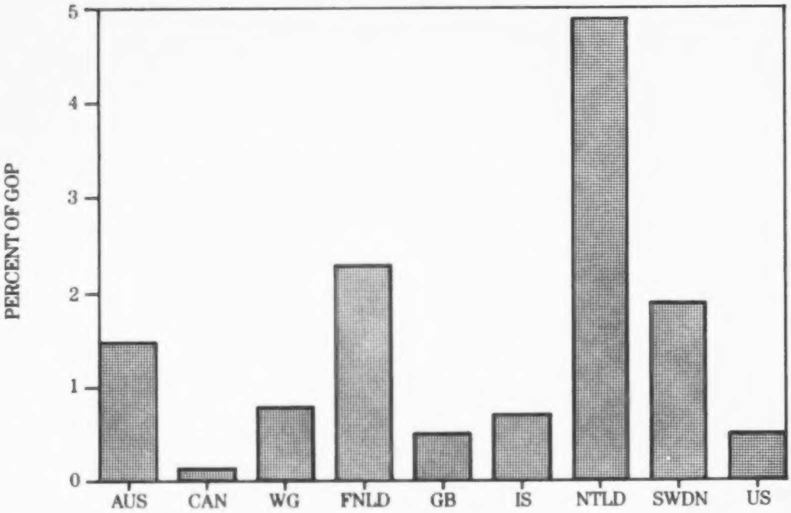
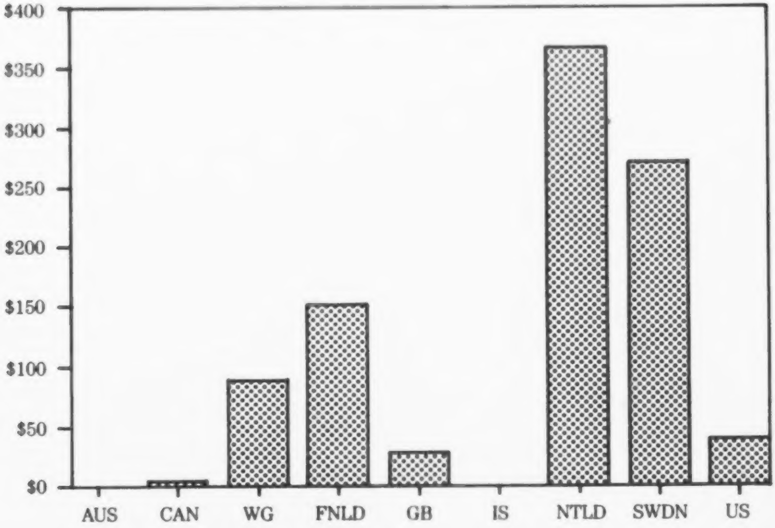


CHART FOUR
REAL PER CAPITA DISABILITY EXPENDITURES
(in 1980 US $)

Across All Nine Countries



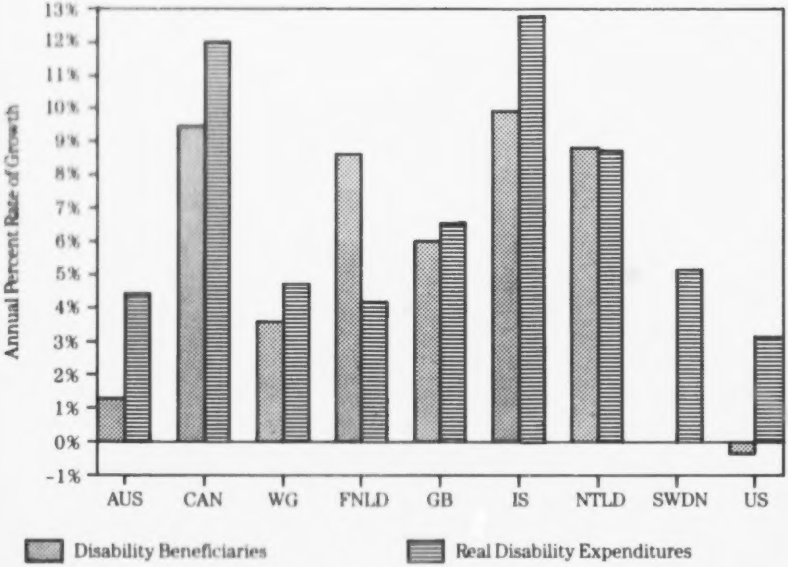
order of $50 per capita or less. It should be remembered that the Finland expenditures consist of private sector payments as well and therefore are not directly comparable. The figures for Israel and Austria are not presented due to inflation and currency conversion problems.

With this data on per capita expenditures it is possible to examine the trends in disability expenditure growth rates previously alluded to. As noted there was a dramatic increase in the level of spending during the early and mid-1970's and then a leveling off during the early part of the 1980's. This trend can be demonstrated in several ways.

One way to show the increase is to examine both the growth rates of disability beneficiaries and real disability expenditures. If the rate of growth of real disability expenditure increases at a greater rate than the rate of beneficiary growth then, a fortiori, the average payment per beneficiary is increasing also. *Chart Five* shows the annual growth in both over the period 1975 through 1983 for the nine countries. Not surprisingly, given the multitude of underlying causes, the different countries have experienced varying

CHART FIVE
ANNUAL TREND GROWTH RATES OF DISABILITY BENEFICIARIES AND REAL DISABILITY EXPENDITURES
Period 1975-1983

Across All Nine Countries

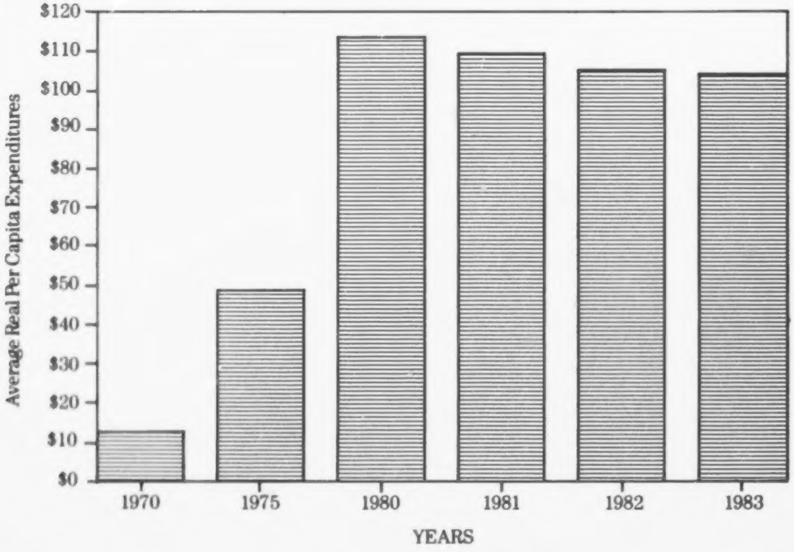


growth patterns. In each case the rate of expenditure increase outstripped the increase in the rate of growth of disability pension recipients.

The countries with the most recently implemented programs—Canada and Israel—experienced the most rapid growth rates in expenditures. These increases averaged more than 11 percent for the period. At the same time, the rate of growth in disability beneficiaries averaged just under 10 percent for these countries. Finland and the Netherlands experienced slightly lower rates of increase with respect to the number of disability beneficiaries. Austria and the U.S. had the lowest rates for disability beneficiaries, with the U.S. actually experiencing a decline for the period. Note that the lowest rate of increase in disability expenditures was still greater than three percent.

To concentrate solely on the rates of programmatic growth, the average per capita disability expenditures can be weighted across all the countries to account for the different population sizes. The weighted-average real per capita disability expenditures are presented in *Chart Six*. It can be seen that expenditures quadrupled from 1970 to 1975, from $12 to some $50 per capita, and then doubled again to $110 by 1980. This figure then steadily declined through 1983 to approximately $100 per capita.

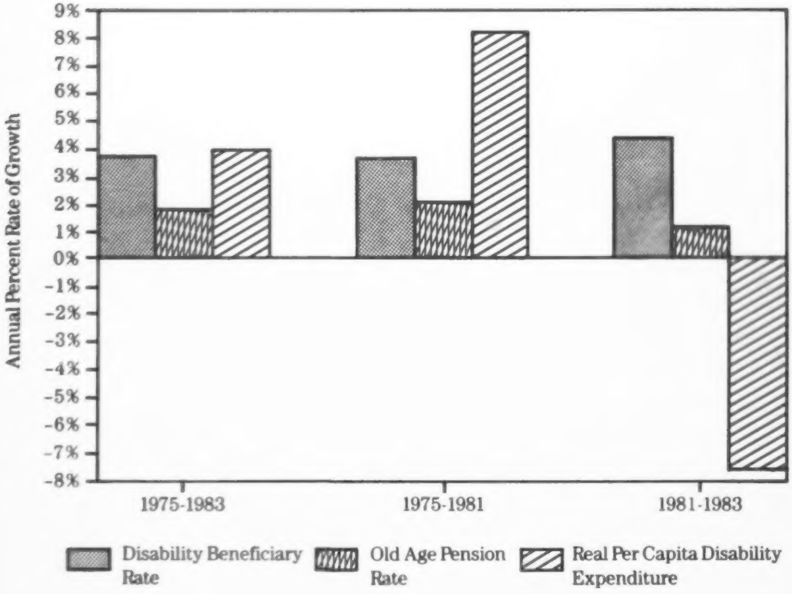
CHART SIX
WEIGHTED-AVERAGE REAL PER CAPITA DISABILITY EXPENDITURES
(in 1980 US $)
Weighted-Average Across Survey Countries Only



A closer examination of this expenditure increase reveals that there was a period of rapid program increase during the end of the 1970's which tapered off during the early 1980's. This is dramatically illustrated by *Chart Seven* which shows that disability expenditures averaged roughly a 4% increase per annum from 1975-1983. However, this period can be further broken down into expenditure changes from 1975-1981 and 1981-1983. While there was almost an eight percent increase for the former period, there was also an eight percent decrease in annual expenditures for the latter period. For comparison purposes, note that the disability beneficiary rate showed about a constant four to five percent increase over the three periods. The old-age pension rate grew at a rate of one to two percent during the same time span.

CHART SEVEN
WEIGHTED-AVERAGE ANNUAL GROWTH RATE of DISABILITY BENEFICIARY and OLD-AGE PENSION RATES, and REAL PER CAPITA DISABILITY EXPENDITURES

Weighted-Average Across Survey Countries



REHABILITATION

It seems obvious that if rising disability expenditures are of concern to a country, one eligible way to reduce these expenditures, and possibly improve overall welfare, would be to rehabilitate disabled applicants and beneficiaries. Essentially this involves providing one or more of a wide variety of services, be they medical or restorative services, counseling and guidance, retraining and education, or possibly the provision of transportation or environmental or job modifications designed to return the worker to the job and to remove him from the disability rolls.

In any country, certain problems are encountered in trying to provide rehabilitation services to persons who are on social security disability rolls who are applicants for benefits, or who may become applicants for benefits if no services are provided. In part, these are the issues or the problems which are encountered in any rehabilitation system. They probably are more difficult to solve in disability benefits systems where one program, geared essentially to determine who is and who is not entitled to benefits, meets up with another program which is clinically oriented, focussed on the individual and geared to his or her voluntary cooperation.

The disability system which seeks to use rehabilitation must have some way to :

1. *Identify persons who could benefit from rehabilitation.*
2. *Devise a rehabilitation plan which details the services to be provided and a timetable for achieving the objectives of the plan.*
3. *Monitor the services so as to assure that they are achieving their desired purposes*
4. *Finance the services, including perhaps maintenance allowances for the person involved.*

None of these tasks is easy to perform as can be attested to by the thousands of persons engaged in the provision of rehabilitation throughout the world. Identification of those who could benefit from services is difficult mainly because of the desire to identify persons early in their periods of incapacity before they become accustomed to receiving benefits and not working at their old jobs. Yet, we know that many (most) persons who leave their jobs because of illness or injury will return to them without the necessity of services of any kind. To screen all persons in anything but the most superficial manner becomes expensive; to wait too long before doing any screening could be to miss the most promising candidates at a time when some rehabilitation could be the most effective.

If there is one article of faith in the rehabilitation community it is that the rehabilitation process should begin early. That belief seems to be shared by administrators in each of the eight countries. Whatever rehabilitation activities there are seem to take place before the persons apply for the long-term disability benefits. In each of these countries, the long-term disability applicant started with receiving benefits from the short-term sickness benefits program and may stay on that program for six months, one year or even longer in the case of Sweden.

While on the sickness benefit program, the person will likely come to the attention of the health care system and, perhaps, even of the labor market authorities and both of these agencies may involve the person in some rehabilitation activity. But it is the social insurance system which is responsible for paying the benefits and which faces the prospect of paying further benefits for some longer period should the person graduate to the long-term rolls. At times, the priorities of these several systems may conflict. The impairment which keeps the person out of work, perhaps cataracts or low back pain, looms large in importance to the social insurance agency if that impairment is the reason for the person collecting benefits. It may not be of equal importance to the health care system which may give priority to those ailments and impairments which are life threatening.

Such problems are encountered in Sweden, just to take one example. Given its unified administration of both the short-term sickness benefits and the long-term disability pensions, the social insurance offices in Sweden are in a good position to monitor persons as they start down the road to what may be permanent invalidity. Although not fully implemented in all social insurance offices, they are experimenting with a system of early identification of persons receiving sickness benefits who are likely to profit by some attention and the possible provision of rehabilitation services. They are experimenting with various computer programs which will identify appropriate persons. One simple test is to select persons who are receiving sickness benefits for longer than a prescribed period—a test used in the New York state workers' compensation system and several other state systems in the United States. More complicated systems are being tested including those which select persons with a pattern of continued short episodes of sick leave in a prescribed period of time. Given sufficient time to test such a system, it is likely that they will come up with a program which can select likely candidates for some rehabilitation attention. They then face the problem of devising a plan of services and carrying out that plan.

The problem the Swedish authorities face at that point is similar to that faced by the programs in other countries. The social insurance personnel are in the business of running a benefits system and not a rehabilitation system. Referrals must be made to the other systems, be they health care systems, labor market authorities or other agencies. The management function, i.e. devising a rehabilitation plan and monitoring it, is not centralized in any one agency. Each agency or authority carries out its own functions in accordance with its own priorities. Although the Swedish social insurance offices employ physicians and persons who may visit homes of persons on sick leave and presumably counsel with them, there is no analogue to the U.S. rehabilitation counselor with authority to devise and supervise a coordinated plan of services.

In Israel, the social insurance system does employ rehabilitation counselors who play a role in the evaluation process as well as in providing rehabilitation services. Their difficulty seems to be in identifying persons early enough. For the most part, they see persons who are being considered for long-term benefits, after they have been on the sickness benefit rolls for a six month period.

In the Netherlands, the Joint Medical Service employs practitioners who are now being given the authority to intervene on their own in certain cases where a person on sickness benefits is having difficulties in returning to his old job, but the bulk of their activities seem to be concerned with identifying candidates and then referring them to the appropriate authorities.

In the Federal Republic of Germany, rehabilitation takes precedence over the granting of a pension. With the entire population covered by compulsory health insurance, much of the rehabilitation activities take place under their supervision. The health insurance funds offer medical rehabilitation and also may supervise the provision of other rehabilitation services. Some of the vocational rehabilitation activities are the responsibility of the local labor exchanges and the social insurance funds must work out cooperative relations with them.

In Finland, the Social Insurance Institute will pay for certain of the rehabilitation services provided by the other agencies, but is not active in initiating such services on its own. The employment related schemes of private insurances which play such a prominent role in the Finnish system has financed a rehabilitation institute which employs counselors who screen applicants for benefits, seek out likely candidates, devise a plan of services and finance these services. This is the most integrated of the plans encountered in any of the eight countries and probably the only one which looks upon its function as a form of loss prevention services. Its objective is to provide those rehabilitation services which are designed to minimize sufficient benefits so as to offset the cost of services.

In the United States, the obvious problems when it comes to the rehabilitation of Social Security Disability Insurance beneficiaries has been the inability to identify these persons early enough, and, perhaps, the limited type of services available to them through the normal rehabilitation channels. For the most part, the traditional rehabilitation agencies in the United States focus on the individual client, his motivations, his skills and his medical conditions. Services are offered to counsel and guide the client, to provide restorative services and to retrain. The eight countries under consideration here have two advantages over the United States. For one thing, they have the potential of identifying clients early because of the short-term benefits and secondly, each of the systems allows the expenditure of funds for services designed to change not only the person, but that person's personal and working environment. If there is less emphasis in these countries' use of a counselor working on a one to one basis with a client, there is more room to provide for wage subsidies for a limited or permanent time, for job modifications as well as for transportation and housing subsidies or allowances.

Given these considerable advantages, why have these countries not made more extensive use of rehabilitation? Why does not each of these countries report great satisfaction with the way they rehabilitate social insurance disability beneficiaries? The answer is two-fold, one of which is most familiar to persons in the United States. The less familiar problem is that of the coordination of the various agencies and authorities with responsibility for rehabilitation, or some related activity. Occasionally what becomes everyone's business ends up being no one's business.

The other and possibly more familiar problem is that of disincentives—a term that is often misused to refer to any and all obstacles in removing a person from the rolls or encouraging him to get on in the first place. In each of these countries, replacement rates, the ratio of benefits to wages, tend to be generous thus encouraging applicants to seek out benefits and to prefer benefit status to the uncertainties of the labor market. In addition, in several of these countries, Austria and Germany just to cite two examples, the eligibility criteria tend to be more liberal for older applicants thus making rehabilitation efforts more difficult. From time to time, in other countries, the program is used to encourage early retirement or as some other instrument of labor market policy and under these conditions rehabilitation efforts can hardly thrive.

But whatever labor market parameters the programs must operate under, it is likely that improvements in rehabilitation are possible. The Finnish private sector orientation could well be applied to public sector programs elsewhere always recognizing that program goals are paramount. The Finns recognize that the expenditure of funds must be justified by the program savings which is probably appropriate for a social insurance program, given all the other agencies available for providing services on some other basis. The Swedes have the potential for the development of an early warning system as do the Dutch. The Israelis have developed a type of coordination of services via trained counselors and the Germans and Austrians have announced the priority of rehabilitation over the provision of benefits. All of these features are required for the system which functions ideally.

A CONCLUDING NOTE: LESSONS TO BE LEARNED

As noted at the outset, the myriad of institutional details surrounding each of the country's systems makes meaningful comparisons difficult. We are acutely conscious of the aspects of the systems we have omitted. Some of these are covered elsewhere in this monograph.

It is probably naive to make cross-national comparisons for the purpose of picking out shining examples in the hope these can be replicated in another country. The pieces of the system in a country form a coherent whole and it is not likely that a part can be borrowed without taking the entire system. What then is the sense of examining the experiences of another country? The answer probably is that only in this way can one gain some objective view of the processes in one's own country and one can then begin to think about ways and means of improving procedures.

The organization of the system is probably its most idiosyncratic feature. The Swedish centralism, the Dutch trade associations, the German and Austrian social insurance institutions are easily explainable in light of each country's experience and development. Yet the Finnish Central Pension Security Institute which serves to coordinate the public and private sector pensions may have some lessons for other countries where coordination is a problem. The differences between the functions performed by the U.S. pension legislation differs only in degree and not in kind, although ERISA is not primarily concerned with disability matters.

An examination of the other countries reveals the U.S. as standing alone in not having a national short-term disability benefits program and one of the few without a partial disability benefits program. That fact alone is not persuasive enough to have the U.S. rush to add these features to the present system. However, there does seem to be some advantage to integrating short-term and long-term programs. Also, there may be some profit in investigating the possibilities of developing ways and means of forging closer links between the national program and the several state and the many private short-term programs that do exist.

An examination of the other countries' experience reveals a wide variety of ways in which the disability determinations are made. Obviously some of these countries which admittedly have smaller programs do devote comparatively more resources to the determination process than does the United States. Again,this is not to conclude that we should bring all applicants in to a central location for a thorough examination and functional assessment. But it does raise some issues that cry out for experimentation and investigation. *Where is the breakeven point? Would devoting more resources to the determination process yield savings to the trust fund?* If someone were inclined to try and find out, the experiences of these countries would yield some interesting models.

If any one lesson can be drawn from this cross-national comparison of the determination process, it is that the intricacies of the formulation of scientific criteria, the testing of the validity of the instruments used, the care taken to see that persons with the appropriate training are confined to making decisions in their own area of expertise—all of these are important but they all give way to the overall policy that drives the program. Whether by legislative enactment, administrative policy or judicial decision, if the driving objective is to provide income to those who leave the labor force early, then that will affect all else in the program.

As we examine the experience in these eight countries, it is probable that, somewhere in this world, there are the technical skills, the knowledge and the conceptual base to make distinctions between disabled persons and nondisabled persons. But the dividing line is not preordained and depends so much on the objectives of the program. These are not a matter of technical skills but public policy. Perhaps, we must first agree on what we want the program to do before we rush to change it.

ENDNOTES

1. This is a report on selected aspects of the experience of eight countries with the development and administration of disability insurance benefits. The study was undertaken by Rehabilitation International under the sponsorship of the United States Social Security Administration. Representatives of the eight countries met in Stockholm, Sweden in June, 1985 to discuss the project. Subsequently each representative wrote a monograph on his or her country's experience and also filled out a detailed questionnaire specifying the statutory provisions of its laws, the administrative organization, the criteria for benefits, as well as the statistical record of benefit levels and payments over the years.

The results of the questionnaire have been tabulated and are available in a condensed version. Compilation of these results has been the responsibility of David Dean, assisted by Steven Yates. Persons who seek more detail about the record or the provisions of the law in each of these countries are referred to these tabulations which are available from Rehabilitation International (RI).

Each country's programs are the product of years of social tradition influenced by changing economic conditions. To compare programs is hazardous, especially if one seeks to extract meaning so that we might learn from each other. But the alternative is only to describe the programs and to recite the similarities and the differences. These comparisons are presented in the tabulations of the responses to the questionnaires where the answers are reproduced with a minimum of editorial comment. The purpose of this cross-cutting study is obviously different. It does not purport to be a comprehensive examination of each country's programs—again, that is the province of the responses to the questionnaire.

Although no attempt was made to cover all aspects of each country's programs, restrictions on length prevented coverage of some aspects which are of obvious interest. I wish that more space could have been devoted to rehabilitation in each of the countries. I have covered some of this material for four of the eight countries in a report for the World Rehabilitation Fund

("Social Insurance and Rehabilitation, The Netherlands, Sweden, Finland and Israel" October, 1985). Copies of this report are available from the World Rehabilitation Fund (WRF).

This report is based on the monographs and the questionnaires but I have felt free to use other sources and to draw on my experiences in the WRF study trip. Needless to say, the opinions expressed and any errors that remain are my responsibility alone.

I am grateful to Rehabilitation International for the opportunity to examine these other countries' programs. To observe common problems being solved in different economic and cultural settings makes one acutely aware of the problems. While the intercultural and cross national comparisons may not always yield immediate solutions, they may open up one's eyes to alternative paths to resolutions of problems. In a world where each nation is so bound up in its own way of doing things, that is a contribution to be valued and a result which may justify our expending the effort it takes for each of us to understand the other's way of attacking these common problems.

2. The distinction between the ameliorative and the corrective responses is set forth in: Robert H. Haveman, Victor Halberstadt and Richard V.Burkhauser. *Public Policy Towards Disabled Workers*, (Ithaca, NY, Cornell University Press, 1984) Chaps.6 and 7. Those interested in a cross national comparison which stresses economic impacts should consult this volume. The countries covered are the United States, Germany, France, Israel, Italy, Netherlands, Sweden and the United Kingdom.

3. The slowdown in growth is evident from an examination of the report on the responses to the questionnaire. See, Steven Yates, "Statistical Highlights of Section 8", February, 1986. Some of the recent trends in social welfare expenditures are summarized in the WRF report referred to above.

4. Edward D. Berkowitz, "The American Disability System in Historical Perspective" in Edward D. Berkowitz, ed. *Disability Policies and Government Programs*, (N.Y., Praeger Publishers, 1979).

5. Helen Bolderson, Report of Visit to Federal Republic of Germany, September 12-14, 1977. SSRC/DFG Research Exchange Scheme for Social Scientists. (Unpublished).

6. American Medical Association's *Guides to the Evaluation of Permanent Impairments* (Chicago, Il, 1976).

7. "Trends in Partial Pensions", EIRR 134, March 1985, pp 17-20.

8. *Ibid*. p.20.

10. It was not until 1983 that Congress reacted and passed the amendments. As Carolyn Weaver has noted, it was not that the solutions were unknown, there was even confusion as to what the problem was. See Carolyn Weaver, "Social Security Disability Policy in the 1980s and Beyond", in

Monroe Berkowitz and M. Anne Hill, eds. *Disability and the Labor Market: Economic Problems, Policies and Programs* (Ithaca, NY, ILR Press, Cornell University) forthcoming.

11. Steven Yates, *op. cit.* Charts 8.7-8.9.

12. See Rehabilitation International, "Cross-National Study of Disability Benefits", Responses to Questionnaire, Section 5.

CROSS NATIONAL STUDY OF SOCIAL SECURITY BENEFITS FOR DISABLED PEOPLE

Synthesis of national monographs and questionnaires

1. INTRODUCTION

1.1

In the final sentence of Chapter One, p. 48, Monroe Berkowitz suggests that

> **"Perhaps we must first agree on what we want the program to do before we rush to change it."**

One of the difficulties with comparisons between social security programs in different countries is that each, almost inevitably, is attempting to achieve a variety of possibly incompatible objectives. Isolating and comparing a single aspect of these social security systems is fraught with even more danger; first because wrenching one part out of a well integrated system may give a false picture of the overall situation of the people under consideration (and it must be remembered that the primary purpose of any system is to serve its beneficiaries); and second, because attempts to compare detailed procedures within such a framework may simply lead to confusion—the reasons for the presence or absence of particular procedures may genuinely not be intelligible within the constraints of the study.

1.2

The U.S Social Security Administration (SSA) asked RI to study those systems in other countries most similar to Social Security Disability Insurance (SSDI). This is a benefit whose purpose in general terms is to provide an income for workers unable to continue working on account of disability. The eight countries studied provide a similar benefit in similar circumstances. To this extent a comparison of criteria and procedures is reasonably simple. The other two prime concerns of the SSA were with "re-evaluation," designed to ensure that people were still genuinely entitled to benefit and to the links between the disability benefit system and rehabilitation programs. It is here that exact comparisons break down and looking at a segment of other systems from a U.S. perspective with the question, "How do you solve these terrible problems we have been having?" is likely to elicit eight replies along the lines, "Our systems are different so we do not have your problems—we have home grown problems of our own."

1.3

One key factor in any country is the presence and level of benefits for unemployment. Since high levels of unemployment appear to augment the disability pension programs, the relationship between benefits for disability and benefits for unemployment must have a major influence both on the re-evaluation of beneficiaries and on rehabilitation and employment programs.

If, for example, benefits for both groups were identical, there would be no purpose in seeking to reclassify people except in the context of moving them off either benefit into employment.

1.4.1

Six areas have been chosen for particular analysis.

1.4.2

Section 2 is an attempt to glean from the monographs and questionnaires an overall picture and the overall objectives of the total social security program in each country and the specific role played by the disability pension program.

1.4.3

Section 3 compares the "nuts and bolts" of each system, with a particular emphasis on the way in which particular groups may find themselves excluded.

1.4.4

Section 4 gives a comparison of the links between the social security and vocational rehabilitation programs in each country.

1.4.5

Section 5 attempts to portray the wide range of other services and facilities provided in each country which may or not be designed to assist the benefit and rehabilitation programs in achieving their goals.

1.4.6

Section 6 looks at two particular groups: people disabled from birth or an early age and workers who become disabled around the age of 55.

1.4.7

Section 7 examines how people with disabilities have or have not been protected from attempts to reduce public expenditure in recent years and the role played by organisations of disabled people.

1.4.8

Section 8 presents a few brief conclusions and recommendations.

1.5

Two words of caution concerning interpretation of the material. First, there is the perennial question of language, especially in translation. Generally speaking the SSDI equivalent in each country is called a disability pension and this is used as the standard terminology despite the fact that the principle criterion in each country is not "disability " in the accepted World Health Organization (WHO) sense, but "incapacity" or the specific inability to work. In some countries, however, "disability benefits" have a wider meaning and the phrases ''disabled people'' and ''people with disabilities'' will almost always be used in the broad sense of people with impairments which have a significant effect on their ability to participate in an unreconstructed society, whether or not they can work, or indeed are working. Sometimes, however, especially when moving from commentary to direct quotation and back again, different phrases may be used to describe the same benefit; but it is hoped that the meaning will always be clear in context.

1.6

Second, without implying any criticism, it is important to realize that four of the reports were provided by program administrators and four by people representing organisations of or for disabled people. It is probably inevitable that the latter are somewhat more critical and also tend to give a wider picture of the position of disabled people excluded by the main programs. My assignment has been to try to discover how disabled people are treated in different circumstances and whether the reasons for the differences are historical, intentional or simply accidental. At times it has been necessary to draw inferences from the data which warranted going back to source for confirmation. Considerations of time and cost, however, did not allow this. It is absolutely certain that the contributors from each country (even the UK!) will find numerous mistakes and misinterpretations; and I hope they will all accept my apologies in advance.

1.7

The purpose of this examination is to compare the goals of each program and to assess whether the structure appears to assist or hinder their achievement. In the end it is political choices, not administrative detail that determines the relative status of people with disabilities. In general the contributors from the eight countries describe their own systems and the commentary suggests aspects which may deserve further consideration.

2. THE OBJECTIVES OF THE COUNTRY PROGRAMS

2.1.1

In Austria the insurance principle is still paramount. Although there have been discussions about the different treatment this causes to different groups,

> **''to reduce these differences is at the same time a humane, economic and political question.''**

As in many countries the highest benefits go to the industrially injured:

> **''Where the payments in cash are concerned, there is a big difference in Austria depending if the impairment was caused by an occupational accident or disease or by an accident in private life or a disease...It is possible that a disabled person after an occupational accident receives a pension from the accident insurance as well as a pension from the pensions insur-**

ance. In case of an accident in private life, the only benefits that are granted are benefits from the pensions insurance if the person was gainfully employed. If the disability is due to a disease and the person was never gainfully employed, the person will only receive social assistance benefits."

2.1.2

There are consequently three different systems:

"1. *Social insurance*
(a) Benefits are granted in the case of an insurance case occurring, if the entitlement prerequisites are met.
(b) Insured persons have a legal right to benefits.

2. *Welfare*
(a) Persons that fulfill special prerequisites laid down in the law are liable for benefits.
(b) Persons have a legal right to these benefits.

3. *Social assistance*
(a) Social assistance only comes into effect... after all other possibilities ...have been exhausted.
(b) Persons in general do not have a legal right to benefits."

Welfare mainly covers war victims, but also includes maternity, marriage and family benefits.

2.1.3

People disabled prior to working age and the chance to become covered by insurance are therefore the responsibility of social assistance. Increased family allowances are, however, payable in respect of disabled children and young people considered permanently incapable of work up to the age of 27. It must, however, be arguable whether paying benefit for adults to their parents through an extension of child allowances is the most effective way to foster independence. Some other countries do the same and there may well be administrative advantages. It may, however, be an indicator that the social security system in Austria has not restructured its approach to take into account the demands of the International Year of Disabled People for "Participation and Equality."

2.1.4

Two other factors are worth mentioning here. First, the pensions paid to those incapable of work are equivalent to retirement pensions and, second, it is possible for women to maintain their insurance status for three years while bearing children.

2.1.5

In summary, the changes in Austria since World War II appear to have been devoted mainly to improving the insurance system for workers. Little thought appears to have been given to the needs of people with disabilities as such.

2.2.1

The social security system in Canada has much in common with the U.S., indeed the disability program itself was modelled on SSDI.

> ***General disability programs*** **provide benefits without regard to the cause of disability. Included are the Canada Pension Plan, the Quebec Pension Plan, private long-term disability insurance, and social assistance, which includes provincially-sponsored programs for disabled persons.**
>
> ***Categorical programs*** **provide benefits to those with specific conditions or in limited circumstances. Included are provincial workers' compensation programs, veteran's benefits, automobile accident insurance and criminal injuries compensation."**

2.2.2

While the general framework is similar to many other countries—an insurance benefit for workers with a means-tested safety net for the non-insured—Canada appears to be in the process of developing alternative systems based on different principles and also to be uncertain whether the future of the disability program lies with the State or with private insurance. As a result there is currently considerable complexity and confusion for the potential claimant.

> **"There are problems inherent in the system because of this fragmentation, and there are gaps and inconsistencies that result in an inadequate level of benefits for many disabled Canadians. Many sources from within government, the voluntary sector and the disabled community are advocating modifications to the system so that it provides more comprehensive and integrated coverage, at a level compatible with the cost of living."**

The system is difficult for professional advisers as well as claimants. A hospital social worker expressed the view that

> **"The biggest problem is a lack of *information* about the social security system, and a lack of understanding about pension availability and eligibility, even within the medical and social work professions."**

2.2.3

In Canada as a whole there does not seem to have been extensive consideration given to the specific financial needs of people with disabilities not covered by the Canadian or Quebec pension plans.

> **"In British Columbia, Alberta and Ontario, however, special disability programs provide higher safety-net benefits and may be seen as a move in the direction of a more adequate minimum standard for totally disabled people."**

2.2.4

There certainly seem to be considerable administrative hurdles to overcome before benefit is obtained and, while many recent developments are commendable, there does not appear to be any overall objective behind the present structure. Canada has been in the forefront in examining the situation of people with disabilities, consulting them and enshrining their rights in the constitution; but the effect of this on its social security program is not yet apparent.

2.3.1

The Federal Republic of Germany (FRG) is credited with the oldest insurance system in the western world, allegedly created by Bismarck to halt

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the march of socialism. Social insurance is compulsory and provides legal entitlements if the prescribed conditions are met.

> **"Social insurance means protection against illness, accident at work, unemployment, invalidity, old age and death. Nowadays nobody can any longer protect himself sufficiently enough against the vicissitudes of life. The social insurance system has been established to support the individual."**

Earlier this century the system was exported to other countries, so it is not surprising to find much in common with the schemes in Austria and The Netherlands. Administration is by a variety of insurance offices and there are strong institutional links with vocational rehabilitation services. Indeed a constant theme is the principle that "rehabilitation has priority over pensions."

2.3.2

There are four branches of social insurance: health insurance, accident insurance, pensions insurance, and unemployment insurance. As will be seen, there are some modifications which assist people unable to make contributions from earnings, but generally speaking it is still a basic earnings-related contributory scheme, and as such has succeeded in preserving the value of benefits. Nevertheless the shrinking of the workforce is causing problems and it is stated baldly that:

> **"It is the duty of the pensions fund to secure the loss of ability to earn one's living but not the end to the ability to earn one's living."**

From this it appears that the funds are intended strictly for the contingencies originally envisaged and not, for example, to accommodate increasing unemployment and the growth of early retirement. Longevity alone will be a sufficient burden on the budgets.

2.3.3

Since 1974 benefits have been provided under the social assistance scheme

> **"to persons unable to help themselves, or who do not receive the necessary help from other people, especially family members, or other social insurance agencies."**

This is similar to Austria; the FRG has not made any real extension to the insurance scheme to include people disabled from birth as The Netherlands did in 1976.

2.3.4

The insurance institutions in the FRG are genuinely democratic.

> **"Elections in the social insurance system hardly differ from political elections: they, too, are free elections by secret ballot on the basis of proportional representation...All the insurants who have attained the age of 16...and the employers have the right to vote. Pensioners have the right to vote too. Elections take place every 6 years."**

2.4.1

Almost the opening words of the monograph from Finland are

> **"The organisation of Finnish social insurance is unusual in Europe."**

The complexity of a national social security system seems to vary inversely with the population of the country it serves. This is not so paradoxical as it may seem since a small country may be able to handle a complicated network which would collapse in a larger one; and a small country may be able to experiment and to adapt its programs more readily than others can. Certainly there are many features of the benefit structure in Finland which are of particular interest.

2.4.

Little has been said about industrial injuries schemes in other countries; but to understand the Finnish approach it is necessary to consider all their programs in some detail. In essence there are four tiers: at the base (where many countries have means-tested local programs) is a national flat-rate pension covering old-age, disability and unemployment.

> **"Every person aged 16 or over who has resided in Finland for five years or more is insured under the National Pensions Act, regardless of nationality."**

The second tier is the standard disability pension for employees and the self-employed—the SSDI equivalent; but above this there are two special schemes for the industrially injured and people injured in motor accidents. The scope of compensation for industrial injury is wider than in many countries including, for example, the families of farmers. The motor accident scheme reflects tort principles and seeks to provide total compensation, including 100% loss of earnings.

2.4.3

It appears that the philosophy in Finland is to set both a baseline and a goal and, while ensuring adequate protection at the bottom, to move particular groups towards the goal in a pragmatic fashion. For example, while the maximum employment pension in the private sector is 60% after 40 years in active employment,

> **"this cannot be achieved in the old age pension until later because of the gradual implementation of the employment pensions scheme. The 60% goal has been partly attained in disability and survivors' pension."**

Most countries look after their civil servants better than the taxpayers who pay their wages, so

> **"The maximum pension for public sector employees and seamen is 66% of the pay. Because their pensions schemes have been in force for a long time, the accumulation coefficient is higher than in the private sector and the insured period required for the maximum pension is shorter, 30 years, the 66% pension goal has already been reached."**

2.4.4

Responsibility for these pensions lies in a partnership between the public and private sector and

> **"the borderline between social and private insurance is indistinct."**

It does appear, however, as if the complications are sorted out within the bureaucracy and the claimant may apply for benefit to any local insurance office and have it transmitted to the appropriate body. Much of the internal complexities arise from deciding who should pay for what—the actual services or benefits to the individual may be identical. The system may well have led to overall improvements in benefits; but it may not be very efficient as administration costs are quoted as 20-23% of benefit expenditures.

2.5.1

Israel has the unique advantage among the countries studied of having constructed its disability benefits program from scratch over the past 12 years. While other countries may be slowly adapting insurance schemes to cope with current levels of unemployment and the needs of people with disabilities who have never been able to work, Israel has succeeded in constructing a system which appears to minimise discrimination between people with equivalent disabilities, although it does have separate programs for servicemen, war victims etc. The traditional insurance approach would have been wholly inadequate since

> **"Israel is a country of immigrants"**

with the consequent statistic that only 16% of recipents of disability pensions are Israeli-born. One would assume that only a minority of immigrants receive social security from their former countries.

2.5.2

Social security is administered nationally by the National Insurance Institute which is an autonomous authority under the Minister of Labour and Welfare.

> **"Collection of income contributions began in April 1970, and payment of disabled persons began on a gradual basis from April 1974. Disabled housewives began to receive benefits from April 1977, and persons disabled from abroad, before becoming Israeli residents, were included in the program from April 1979. In the same year, benefits were extended to include an attendance allowance for severely disabled persons including severely disabled housewives. It was only in April 1981 that the provisions for inclusion of disabled children became operative."**

2.5.3

Apart from the basic disability pension program which is simpler, fairer and more generous, policy in Israel has developed in a remarkably similar fashion to that in the UK, with emphasis on additional benefits paid on functional criteria. The advantages of the "cash" approach to needs which other countries may meet by service provision are that more choice is left to individuals as to how they organise their lives (which in itself may be rehabilitative) and the administrative costs may be far lower. Disadvantages may be that the benefits may prove insufficient to purchase the assistance required and may not be attuned adequately to individual need. Equally the rigid criteria necessary in a benefit system does not allow the latitude available in a service delivery system where each need is individually assessed. The criteria for attendance and mobility allowances will be described in section 5 and the benefits for children in section 6.

2.6.1

Sweden appears to have by far the simplest, and arguably fairest, disability pension scheme of all the countries studied.

> **"National insurance, which is compulsory and covers the entire Swedish population, comprises health insurance and parental insurance, basic pensions and general supplementary pension. This insurance scheme is administered by the National Social Insurance Board and regional social insurance offices."**

The scheme was introduced in 1914 and has undergone surprisingly few modifications. At that time

> **"Pensionable age was 67, but a pension—known as invalid pension—could be paid to an insured person below this age suffering permanent disability. The insured was deemed disabled in this sense if, owing to age, physical or mental illness, disability or deformity, he was no longer capable of supporting himself by work corresponding to his strength and skills."**

2.6.2

Perhaps to a greater extent than in any other country, disability pensions have been viewed as a form of early retirement rather than an extension of a sickness benefit. This may explain the way in which the traditional medical criteria have for older workers become more and more relaxed over the years until they have effectively disappeared altogether.

> **"What was originally an exclusively medically based system of permanent disability pensions in Sweden has, in the case of elderly persons, tended more and more to regard unemployment per se as a manifestation of reduced work capacity."**

2.6.3

The details of the changing policy will be described in section 6. It is interesting how different countries choose slightly different justifications for enabling disability pensions to become an unemployment benefit for particular groups. The statement quoted above is only one step away from admitting that the real reason for paying a pension is lack of earnings per se, not the particular reason for the lack of earnings.

2.7.1

The SSDI equivalent in The Netherlands, benefit under the Disablement Insurance Act, is one of the key elements of a complex, but well integrated social security system. There appear to be two principles, one of long standing and still largely intact, the other a flower of the 1970s which has been badly damaged by the frosts of the 1980s. For a long time:

> **"The basic premise of the Dutch social security system has been that every individual has the right to an income which allows him or her to obtain the necessities of life."**

Since this principle applies to all citizens, not just those who are disabled, the safety net in the Netherlands is still fairly robust, at least in absolute terms. This did not, however, satisfy the aspirations of the Dutch for a fairer society:

> **"During the 1970s, Holland was a country in search of social renewal, directed at the fulfilment of everyday needs."**

2.7.2

In its 1975 budget the Netherlands Ministry of Social Affairs expressed the new philosophy in optimistic terms:

> **"Due to our system of social facilities, the Dutch people have been freed from poverty and, even further, those forced to rely on social benefits share, on the whole, in the increasing prosperity..... In a time of critical unemployment, extra attention must be paid to the more vulnerable groups on the labour market. By this we mean young people, the handicapped, senior citizens and women in particular".**

In addition, therefore to the provision of basic incomes for the entire population, the special needs of disabled people were to be met by a wide array of special services, to a large extent financed by the same insurance funds that pay the benefits.

> **"Such services and facilities are intended for purposes of reintegration and increasing the handicapped person's chances to take part in social life."**

2.7.3

Once these objectives of social policy have been accepted, it is soon recognized that only a small minority of people with disabilities will be able to afford to purchase these services and facilities from their own resources:

> **"More than others, the handicapped and disabled are dependent for their income on a social security system as part and parcel of the public sector. They are largely dependent on government policy in the public sector for the assurance of a full-fledged position in society. This dependency applies to facilities in areas such as education, public health care, access to public transport, the addition of guide marks for the blind on important pedestrian routes, social insurance, adapted housing, accessible buildings etc."**

Unfortunately it will become apparent in Section 6 that the government in the Netherlands appears either to have lost sight of the objectives or to have failed to recognize the essential link between the services which have been built up in the 1970s and full equality for people with disabilities in society.

2.7.4

Nevertheless the benefit system itself still provides basic support for people who are unable to earn a living. The specific benefits for people unable to work will be described in Section 3. For insured earners they are higher than the alternatives, but these, as will be seen, are still by no means insubstantial.

2.7.5

As eligibility for one benefit ceases or is denied, people in The Netherlands pass down a ladder of benefits. For example after Unemployment Benefit runs out, the local authorities will pay benefit under the Unemployment Benefit Act for up to two and a half years and subsequently under General Unemployment Assistance. Finally for people ineligible for these,

> **"the General Assistance Programme provides all residents in need with a benefit of a maximum of 70-100% of the minimum wage level and/or reimbursement of exceptional costs."**

This final rung of the ladder is, however, based on a family means test.

2.7.6

In summary, therefore, Disablement Benefit in The Netherlands is, however important, only one element in a structure designed, at least in theory, to provide equal opportunities for people with disabilities and genuine security from absolute poverty for all citizens.

2.8.1

The United Kingdom has had every opportunity to establish a simple and comprehensive social security system. The proposals of the 1942 Beveridge report were widely acclaimed and, despite a few defects, formed a basis which could have provided genuine security for disabled people. Unfortunately

> **"the government of the time radically amended Beveridge's proposals... Rates of sickness benefit were set below the level of National Assistance (called Supplementary Benefit since 1966). Despite improvements in benefit levels since then, insurance benefits in the United Kingdom are still among the worst in the western world. The ostensible reason for a low level benefit was that the Government wanted flat rate contributions which the poorest worker could afford. The Government also decided to accelerate the payment of full retirement pensions rather than phase them in as Beveridge recommended. This inevitably depressed the level of benefits."**

It is the nature of politicians to view matters in the short term rather than the long which may make them particularly unsuited for responsibility for insurance programs! On the other hand, they may well be more responsive than insurance institutions to needs of minority groups. Both these idiosyncrasies have helped construct the patchwork quilt which passes for a social security system in the UK today.

2.8.2

All cash benefits in the UK are ultimately the responsibility of one Government Department, the Department of Health and Social Security

(DHSS). As the Department is also responsible for the National Health Service (NHS) it is not easy to explain why there is such a variety of benefits in the UK and minimal co-operation between the benefit system and rehabilitation.

2.8.3

The answer to the first question probably lies in the failure of successive Governments to establish a clear approach to social security. The Beveridge proposals were based on traditional insurance principles; but because the rates were pitched below the means-tested safety net, large numbers of sick or disabled people, and—numerically most important—of old age pensioners, would have to receive two benefits—an obvious administrative absurdity. One solution, over time, would have been to increase the national insurance benefit rates more than the means-tested rates, but Governments have always feared the appearance of giving more to ''rich'' pensioners than poor ones. In 1975, as an alternative, an earnings related additional pension was introduced which, when fully mature after 20 years, would have lifted almost all pensioners above the level of means-tested benefits.

2.8.4

The calculation of additional pensions was designed to favor low-paid workers, and also, by a ''best 20 years rule,'' it assisted people who became disabled in mid-life or whose earnings declined as they grew older; it also assisted people who took time out of the work force to care for children. It did nothing, however, for people never able to earn, so a Non-contributory Invalidity Pension was introduced (since renamed—see Section 3); yet since it was only 60% of the basic insurance benefit, it was so far below the means-test level that it was really only a symbol of concern for people disabled from birth or childhood.

2.8.5

Of far more significance was the introduction in the 1970s of attendance and mobility allowances in recognition of the extra costs of disability, regardless of whether someone had an income from work or not. A substantial proportion of the total benefits for people with disabilities is dispersed through these two allowances which will be described in Section 5.

2.8.6

Basic income support for non-earners has, however, been under continual attack. Earnings-related additions to short-term benefits have been abolished. Invalidity Benefit itself has suffered a series of cuts in the last few years: a 5% cut from 1980-85, reduction in disregarded earnings of a spouse, abolition of child additions if spouses's earnings are too high, abolition of right to receive both additional pension and Invalidity Allowance (see Section 6) and finally in 1986 the halving of future additional pensions themselves. In the Social Security Act 1986, the Government has signalled its policy of downgrading state insurance benefits and converting the old safety net of means-tested benefits into the cornerstone of the system. For any substantial benefits above basic pensions people must look to private and occupational schemes, neither of which are structured to meet the needs of many people with disabilities.

2.8.7

The background to the current UK benefit structure for disabled people has been given at some length as it is genuinely difficult even for UK specialists to predict in what direction it is heading, particularly since the traditional all-party consensus on pensions has broken down. Any change of Government in 1987 will almost certainly lead to further significant structural changes.

2.9.1

Although the "SSDI equivalents" in each country have much in common, it is apparent that their significance for people with disabilities varies considerably. In no country is the effect of losing the particular benefit as stark as it is in the U.S.; and key issues there, such as loss of medical coverage or the effect of different judicial jurisdictions making conflicting rulings on a supposedly national benefit simply do not arise in the other eight countries.

2.9.2

Although the insurance principle can be seen at the base of all the benefits systems, the current emphasis on individual contributions bringing individual rights in the event of the contingency of incapacity for work varies widely. Austria and the Federal Republic of Germany are the most firmly rooted in traditional insurance and people who have never become insured are the responsibility of social assistance schemes which are not clearly defined. The Netherlands, with similar insurance institutions, has managed to give basic disability pensions to people disabled from childhood, but connection with the workforce is still essential for people disabled at a later age. Canada, despite a national scheme, is still very similar in its approach to the FRG; in the UK the non-insured have been included, but only in a half-hearted fashion. Only in Finland, Sweden and Israel is the basic scheme open to people who have never been able to work; and in Finland the effect is very similar to that in the UK as only a small part is not means tested.

2.9.3

Full data was not always provided on either unemployment benefits or on means-tested safety nets, but is is clear that the next rung on the ladder down from the SSDI equivalent is generally less of a drop than in the U.S.; the safety nets also appear more secure and more generous, even though in some countries they too are local and may not be uniform. The effect of this is that the benefit decision may not be quite so important for the individual if the effect of benefit denial is to be passed to another adequate program of support.

2.9.4

The details of adjudication are considered in Section 3; but it is appropriate to consider the basis of the schemes in the wider context. The "father" of social security in the UK, Lord Beveridge, has been quoted as saying that the basic needs of people out of work on account of unemployment or disability are similar, and while no country has been able to abolish the distinction entirely, there are indications that some find it difficult to justify. The quotation from Sweden in 2.6.2 shows the logical contortion required to acknowledge Beveridge's principle without admitting it: for older unemployed workers the disability pension is not paid because they are unemployed but because their unemployment itself indicates incapacity for work.

2.9.5

Of course, the world not being an ideal one, all governments have to decide how resources should be allocated and to recognize that while some people obviously need and deserve benefits (whether or not they have "earned" them through contributions), others can and should be working but may be content to live on benefits. Some countries such as the FRG and The Netherlands have, as we shall see in section 3, effectively converted their disability pension into an unemployment benefit for people with disabilities by allowing upgrading of partial pensions during unemployment. The logic is either similar to Sweden's—that unemployment indicates incapacity—or the undoubted fact that people with disabilities have more difficulty finding work. Yet when all the countries are suffering high unemployment and it is apparent that wealth creation will increasingly demand less and less human labour, this pragmatic distinction between people who cannot find employment will also become less easy to justify.

2.9.6

Another general theme which occurs through the sections is the different emphasis among the countries between benefits payable on account of inability to work, and benefits payable on account of the extra financial needs of people with disabilities whether or not they are able to work. At this point discussion becomes bedevilled by application of the English word "disability" to both types of benefit; and the problems are discussed at length in the Chapter on definitions. What is absolutely essential to understand, however, and to incorporate within social security systems, is that severe physical impairment and inability to work have no necessary connection. Loading benefits for people with disabilities into a system which caters only to the non-employed not only devalues disabled people, but actively punishes them for working. Conversely, the effects of generous earnings replacement schemes can be seen to encourage disabled people to "retire" early on benefit. While many countries include extra benefits within their disability pension programs—i.e. for those not working—the UK and Israel in particular have struck out with entirely separate schemes for the extra costs of attendant care and mobility.

2.9.7

Many countries, of course, meet the extra expenses of people in work in other ways, often in the belief that helping people to remain in employment will lead to benefit savings. The pendulum can also swing too far in the other direction: for example, to lose one's mobility help at the same time as losing one's job can be a crushing blow. If equity *between* people with disabilities is considered a desirable principle (and with the plethora of special schemes for special circumstances in most countries this has never seemed high on national agendas), then there is a strong argument for all benefits or services (apart from specific job-related assistance) to be entirely unrelated to the employment status of the individual.

2.9.8

All the countries, of course, provide social security benefits for people in retirement. Yet the relationship between the disability pension and retirement pensions is very varied. In this context far more information is needed on private and occupational pensions to make accurate comparisons, but there are significant variations in approach which may depend on whether the disability pension is seen as a long-term sickness benefit or an early retirement pension, i.e., whether the comparison is with pensioners or people of the same age in work. In countries such as Austria and the FRG where the benefit is directly related to contributions, benefit size presumably approaches retirement pension levels the longer one has worked. In most other countries benefits are roughly comparable, but in Finland and The Netherlands the earnings-related schemes give disability pensioners significantly higher benefits than retirement pensioners. This may not only raise issues of equity between different beneficiaries at a point of time, but also the issue of a fall in benefits when a disability pensioner reaches retirement age. No conclusions can be drawn from the current study; but it is a further indication that single benefits cannot be considered in isolation not only from other benefits but also from the range of private schemes in each country.

3. BASIC CONDITIONS AND PROCEDURES

3.1.1

Social Insurance in Austria is subdivided in three branches: accident insurance, health insurance and pensions insurance.

> **"There are 28 social insurance institutes in Austria: 19 health insurance institutes, 3 pensions insurance institutes, 1 accident insurance institute and 5 insurance institutes for certain occupational categories."**

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(The single accident insurance institute is the RI member Allgemeine Unfallversicherungsansalt)

3.1.2

Both the accident and pensions insurance programs cover far more than income benefits, but the distinction in services provided seems to be increasingly a matter not of quality but of the funding mechanism.

> **"The differences between an occupational accident and a non-occupational accident or a disease are more and more diminishing where the benefits in kind are concerned (same treatment in the same institutions)."**

3.1.3

Sickness benefit is provided under health insurance for up to 78 weeks.

> **"The size of the benefit is calculated on the basis of the insured's earnings immediately preceding the illness (provided the earnings do not exceed the maximum calculation basis). The sickness benefit amounts to 50% of earnings for the first six weeks, rising to 60% from the 43rd day of incapacity to work onwards. Supplements are available for the insured's wife and other dependents. The maximum payable is 75%"**

A revised scale is used if the claimant is in hospital.

3.1.4

The nearest equivalent to SSDI are the benefits paid on account of incapacity under pensions insurance. The criteria for benefit are not identical under different schemes.

> **"The following groups of persons insured are entitled to benefits from the pensions insurance:**
> **—incapacity to work pension: employees, certain self-employed persons**
> **—invalidity pension: workers**
> **—permanent incapacity for gainful occupation pension: self-employed in agriculture and forestry, self-employed in trade, commerce and industry. Civil servants are not pensions-insured as they are entitled to other benefits through their work contracts."**

The restrictive nature of social insurance is loosened somewhat for deserving cases:

> **"Apart from the persons named above, the following persons are entitled to benefits from the *accident insurance*: civil servants, school children and students as well as persons not accident-insured (e.g., housewives) that have an accident while trying to save the life of another person or as a helper or member of a voluntary fire brigade, red cross, the avalanche warning services and similar institutions."**

3.1.5

The insurance conditions are fairly rigorous: either 20 years insurance in total or 5 out of the previous 10 years. (As will be seen in section 6, these conditions are relaxed for young people and increased for people approaching retirement age). On the other hand:

> **"1. Periods during which the insured was entitled to draw unemployment benefits are considered as insurance periods.**

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> **2. The first year after the birth of a child is considered an insurance period. The following two years can through voluntary self-insurance or continuation of insurance at special rates become insurance periods that lead to an eligibility to a pension."**

Caring for a severely disabled relative does not, however, retain benefit eligibility.

3.1.6

Calculation of benefit is complex and it will suffice to say that it is based on the income during the previous 84 months, and the number of years of coverage. There are supplements for those under 50 and for mothers. Although the definitions of invalidity and incapacity vary slightly in relation to job comparisons the core test for each is as follows

> **"The insured person is considered to be incapable of work if his/her working capacity because of his/her physical or mental condition has decreased to less than half of the one of a physically and mentally healthy insured person of similar training and similar knowledge and capacities."**

The main distinction between the definitions appears to be that "employees" and skilled workers are not required to take **"a step down in the social scale;"** unskilled workers are assessed against the requirements of any available job. For the permanent incapacity for gainful occupation pension, as the name implies, the person must be considered permanently incapable of performing a regular occupation. For the other benefits the incapacity must be assessed to last for at least six months.

3.1.7

The assessment of incapacity is undertaken by the insurance institute.

> **"The doctor has to define the type of work that the insured person can still do taking into consideration his/her state of health. He in particular has to determine what the person claiming a pension is suffering from and which work the person can still do considering his/her physical and mental condition. This evaluation should not only define the type of work (easy or difficult), but also indicate in which position (only sitting or also standing or walking) the work can be done and if the person needs breaks. The doctor is not supposed to indicate specific occupations."**

No account is taken of the views of the treating physician. Independent medical evidence is only obtained in event of an appeal.

3.1.8

The appeals process in Austria was under review at the time of the study and from 1987 new special social courts will hear appeals against benefit refusal. Currently, appeal is to special arbitration courts. Once an appeal has been lodged,

> **"the official notice of the social insurance institute becomes invalid and the social insurance institute from that time on is not acting as an authority, but is a party complained against just like in a civil suit between private legal entities."**

There is a further appeal on points of law to the Vienna Provincial Supreme Court. In Vienna itself in 1983, the Pensions Insurance Institute for

Workers decided 10,536 invalidity pension claims and found in favour of the claimant in 5,768 (55%). Some 45% of those rejected appealed and 42% of these were successful.

3.1.9

These figures are not very impressive inasmuch as they suggest considerable anguish and effort on the part of claimants. Normally speaking, an initial failure rate of nearly 50% would indicate either that the benefit system is so complex that claimants cannot assess their chances of success (or have applied to the wrong institution) or that the system as a whole is not responding to the needs of a large number of sick and disabled people and claims are made for the only possible benefit more in hope than expectation. Yet a possible interpretation of the criteria mentioned in para 2.1.2 is that the bodies responsible for *social assistance* may require prior claims for social insurance. Systems which are based on a tier of agencies are likely to involve a higher proportion of unsuccessful claims as entities seek to ensure they are not picking up a bill which could be laid at another's door. Whether the interests of disabled people are best served by such procedures is doubtful. Not only is there likely to be delay in obtaining the eventual benefit, some claimants may drop out en route.

3.1.10

One interesting feature of the Austrian scheme is that beneficiaries are not required to report medical improvement, only actual return to work. Medical re-evaluation is only made in specific cases e.g., if medical recovery is expected. Reviews of eligibility are stated to be a major problem, but no reasons are given.

3.1.11

Little can be gleaned from the data concerning the claimant's viewpoint; but the impression given is that those who do qualify, especially after many years of work, receive a substantial benefit on fairly generous criteria and that, once awarded entitlement, is likely to continue with little question until pension age unless the claimant returns to work. The insurance institutes seem to serve their members well; but there is no universal system for people with disabilities in Austria, let alone one which is responsive to their expressed needs.

3.2.1

In Canada the equivalent to SSDI is the Canada Pension Plan which with the Quebec Pension plan covers 92% of workers (employed and self-employed) for both disability and retirement pensions. The definition of disability used is a stringent one:

> **"a person shall be considered to be disabled only if he is determined in prescribed manner to be suffering from a severe and prolonged mental or physical disability...**

> **(i) a disability is *severe* only if by reason thereof the person...is incapable regularly of pursuing any substantially gainful occupation,**
> **(ii) a disability is *prolonged* only if it is determined in a prescribed manner that such a disability is likely to be long continued and of indefinite duration or is likely to result in death."**

The inclusion of **"or is likely to result in death"** in the definition of **"prolonged"** is presumably intended to make it easier for people to qualify. Yet

> **"Cancer patients are also often not well protected by the system. One case involved a man with terminal cancer who applied to CPP and was told it would take six months to receive benefits. In six months he was dead."**

3.2.2

Two other points should be considered in relation to this definition. First, it may not always be advisable to tell the claimant he is dying, although the system probably allows sufficient obfuscation where this is appropriate. Second, there is no necessary link between a permanent or even life-threatening condition and incapacity for work. The requirement is that the **condition** must be prolonged, not the **incapacity for work,** so that people should be eligible during periods of lengthy but reasonably determinate medical treatment for a condition which will be permanent (e.g., following spinal injury), but not for one which may result in total cure. Canada follows the U.S. in having two separate tests to pass—disability and incapacity—without, to my mind, being absolutely clear as to which groups it is intended to exclude or why.

3.2.3

The disability pension (CPP) would normally follow 15 weeks sickness benefit under unemployment insurance—a comparatively short period. It would seem, however, that administrative delays may often leave a gap before benefit is received.

> **"Most people either proceed to CPP or receive long term disability benefits through private insurance for a period of one to two years before eligibility for the pension is ascertained."**

Since the average time for processing a CPP claim is 4 months, a claim would need to be made at the very beginning of the sickness benefit period to have an even chance of avoiding a hiatus between the two benefits.

3.2.4

The contribution conditions are fairly tough. Workers

> **"must have contributed during a minimum qualifying period (at least 5 of the last 10 years and 1/3 of the total contributory period.)"**

Coverage may be retained during unemployment so long as this condition is still met; moreover a parent who stays at home to care for a child under seven may not necessarily have this period included in determining eligibility. On the other hand some disabled people (as well as those disabled from childhood) may have problems in gaining or maintaining eligibility.

> **"Psychiatric patients experience a lot of difficulty with the system. Although they might need a pension, many don't qualify for CPP because they have a sporadic work history."**

3.2.5

The level of benefit under CPP is, however, low.

> **"Among earners, many disabled persons suffer a severe drop in their previous living standards despite benefits from one or more programs"**

It is estimated that 14% of CPP disability pensioners depend on provincial social assistance to make ends meet. It is therefore hardly surprising that an estimated 25% receive another insurance benefit. In fact 43% of the labour force are covered by long-term private disability insurance which appears not only to provide more income, but to operate faster than CPP. CPP benefits are deducted from this private insurance; it would appear therefore that some people have to go through the assessment process for CPP with no advantage to them. While governments may see political advantages in the private sector taking increasing responsibility for disability benefit provision, there seems little sense in operating two parallel administrative systems. Of course there are more fundamental reasons for examining the merits of "privatisation"; it would appear that in Canada a two-tier system (CPP/social assistance) is being converted into a three tier system (private/CPP/social assistance). The additional protection from private schemes seldom is much help to people already discriminated against by national insurance schemes: those disabled from birth or when outside the labor market, and those whose disability seriously limits their earnings.

3.2.6

Canada has a workers compensation program similar to other countries.

> **"This program can provide high earnings replacement and effective rehabilitation efforts for those who have suffered either a temporary or permanent, total or partial disability."**

3.2.7

In many countries there is concern whether the traditional methods of obtaining compensation through the courts could be modified in some way. New Zealand, for example, in its Accident Compensation Act provided earnings-replacement for incapacity resulting from an accident in all circumstances and abolished the right to sue for damages. Traditional litigation, certainly in the Anglo-Saxon tradition where both cause and negligence must be proved, provides fat incomes for lawyers and insurance companies but is little more than a lottery for people with disabilities.

3.2.8

A particularly fruitful area for reform is road accidents because methods of funding compensation schemes are easily devised. As will be seen, while

Finland chose to model a scheme on workers compensation, Canada chose strict liability.

> **"A high level of protection against injury through *mandatory automobile accident insurance*: Automobile accident insurance can provide full compensation for accidental injury. Because such insurance is mandatory, almost all Canadians are protected against disability incurred in an automobile accident."**

This is in marked contrast, say, to the UK where compulsory insurance is designed principally to protect the driver who causes an accident from the cost of any damages he may incur if he is proved to have been negligent. By no means do 100% of road accident victims (even innocent ones) receive compensation. Strict liability, however, has its limitations. Cause must still be proved: not a problem in road accidents, but almost as insuperable a hurdle as negligence in relation, say, to alleged drug damage. The European Community has been wrestling with product liability for several years; it remains to be seen whether the ordinary citizen will benefit. Intellectually attractive as they may be, no-fault schemes which are still based on cause are an irrelevance to the vast majority of people with disabilities.

3.2.9

The CPP is a nationally administered program and appears from the description to be somewhat remote from the individual disabled person. Application is by questionnaire:

> **"This lengthy questionnaire is often confusing to the client, and a social worker is frequently called upon to assist in filling out the form. It is difficult to get in touch with CPP officials by phone to obtain more information, and it is not uncommon for the client to be informed sometime after applying that needed information is missing. The claim is not processed until the form is completed, so delays occur."**

3.2.10

There are three levels of appeal: agency review, a tribunal of lay persons —one appointed by the applicant, one by the CPP administration and the third appointed by the other two members (an interesting and unusual system)—and the Pension Appeal Board. In 1983, over a quarter of the initial applications were denied initially, but the success rate on agency review was very high—over three-quarters—and several more claims denied on review were settled before reaching the tribunal—185 out of 270 appealed. In fact the tribunals only actually had to decide 70 cases and the Pension Appeal Board 16. These figures suggest that there is scope for improving initial application procedures. Administrators sometimes forget that benefit refusal can have harmful psychological as well as financial consequences for disabled people and high initial failure and reversal rates are a cause for concern.

3.3.1

In the Federal Republic of Germany

> **"during the initial period of an illness the insured person always con-**

tinues to receive wage or salary payment from the employer for the first six weeks. After this, sickness benefit is paid by the health insurance fund. It is also during this period that consideration is given to the question of whether medical or vocational rehabilitation is necessary".

Sickness benefit can be paid for up to a maximum of 78 weeks within a period of three years on account of the same illness. It does not dovetail precisely with longterm incapacity benefits as in most countries. Although sickness benefit will cease if an *earnings incapacity* pension is awarded it can overlap with the award of, and be reduced by the amount of, *occupational* incapacity pension.

3.3.2

The English translation of these two benefits is not consistent. *Earnings incapacity* pension is also called 'disablement pension' and *occupational incapacity* pension is called a 'semi-disablement pension'. Since the latter are slightly less cumbersome and easier to relate to the criteria they will be used except in direct quotations.

3.3.3

The semi-disablement pension may be awarded

"when an insured person, on account of disease, accident, or other ailment, is capable neither in his training profession nor any other suitable occupation, to perform and earn half of what other employed persons with similar training and equal knowledge and capabilities would."

The disablement pension may be awarded to an insured person who

"due to illness or other ailment or on account of weakness of physical or mental functioning, can engage only irregularly in gainful activity, or, though capable of following such activity on a somewhat regular basis, can achieve only insubstantial income from it."

It may also be paid to someone who is only "occupationally incapacitated" (i.e., eligible for semi-disablement pension) who cannot be offered suitable employment. A supplement to cover health insurance may be added to either benefit.

3.3.4

Assessment is by a doctor employed by the pensions institute.

"Assessment of earning capacity is not primarily determined by medical diagnoses or findings, but by the implications existing health problems have relative to physical or mental capacity in working life. Hence, a so-called positive and negative performance profile will be established by the appropriate expert, i.e., stating activities that can be performed and those that can no longer be performed. Assessment of earning capacity, hence, is not alone a matter of the nature and extent of a health impairment, but essentially dependent on the resulting disabilities and handicaps."

Since the assessment for benefit is closely aligned with the assessment for vocational rehabilitation, it is discussed further in Section 4.

3.3.4

The minimum period of insurance before eligibility for benefits is five years. Voluntary contributions may, however, be made by homemakers; and

> **"persons disabled from an early age can be covered by the scheme if they pay voluntary contributions for a period of 20 years, beginning at age 16."**

People working in sheltered employment are covered. Perhaps the most significant modification is that 12 months of coverage are awarded per child to protect women during child rearing periods.

3.3.5

There is an apparent discrepancy between the German monograph and questionnaire as to whether it is necessary to have worked immediately before claiming. Monograph:

> **"...pension is awarded...to every insurant who...has been engaged in compulsory insured employment immediately prior to claiming..."**

Questionnaire: "In order to be eligible... must a claimant have... worked for a particular period of time immediately before the claim."

> **"No; benefit eligibility is however subject to the condition that obligatory contributions were paid for a minimum of 36 months within the five years immediately prior to the onset of ...incapacity."**

In either case, however, the value of voluntary contributions during non-employment appears to be limited. The size of the pension is related directly both to past earnings and to the number of insurance years, without apparently a basic minimum.

3.3.6

Either pension may be awarded either indefinitely or for a fixed period of time.

> **"A fixed-term occupational or earning incapacity pension is awarded if, from the medical perspective, the earning incapacity is only of a temporary nature. Maximum duration of a fixed-term pension is 3 years, and may be extended for another three-year period. The benefit may be temporary also in those cases where the occupationally or earning incapacitated person is unable to secure reasonable employment."**

Indefinite pensions commence the month after the eligibility criteria are satisfied; but fixed-term pensions are delayed for 6 months in order to avoid pension benefit awards for short-term conditions. Benefit terminates automatically at the end of the period and the recipient must submit a new claim for its continuation.

3.3.7

Benefit receipt is contingent upon the continued presence of incapacity and the beneficiary is legally bound to report any changes in his state of health or any work undertaken. There is, however, again a slight discrepancy between monograph and questionnaire on the question of monitoring. Monograph:

> **"The pension insurance administrations...re-evaluate the beneficiary's earning capacity from time to time."**

Questionnaire:

> **"Beneficiary re-evaluation to determine continued eligibility for collecting an...incapacity pension is not normally the case."**

The former statement possibly represents historical intentions and the latter current practice.

3.3.8

The are two levels of appeal, the first is internal to an "objections board" and the second to the social court, with further appeal to the Federal Social Court on points of law. No statistical data are provided.

3.3.9

The data from the Federal Republic do not shed much light on the way individual people with disabilities are treated. The system, however, appears to serve well those who have been insured for a long period before becoming disabled. In particular, as in The Netherlands, the disablement pension serves as an unemployment benefit for those only 50% disabled who cannot find work. Even with comparatively low unemployment this has afforded substantial protection to these disabled people. In 1965 the ratio of full to partial pensions was 2:1, in 1984 11:1.

3.4.1

In Finland there are four separate schemes which will be referred to as the national disability pension, the employment disability pension, the accident disability pension and the motor disability pension. In general the first two follow a year after sickness benefit which is paid on a daily basis. The medical criteria for all four schemes are similar: *The national disability pension* is payable to people aged between 16 and 65

> **"who, because of an illness, defect, or injury, are unable to maintain themselves by their usual work or any other kind of work which, considering their age, occupation, education and place of residence, would be suitable for them."**

Possibly a throwback to a former benefit system also gives entitlement to

> **"a person who is permanently blind, unable to move or is otherwise helpless."**

3.4.2

The employment disability pension can be paid to any employee or self-employed person. Someone

> **"whose working capacity is assessed to have been impaired continuously by at least three fifths for a year....owing to an illness, defect or injury, is eligible for a full disability pension. A loss of working capacity of at least two fifths makes him eligible for a partial pension. In addition to medical factors, social circumstances such as age, training, work available and housing conditions are taken into consideration in assessing the impairment of working capacity. When the capacity to work is varying, the annual earnings are taken into account."**

For both the national and employment disability pension disability must be expected to last for at least a year. There is an agreement between the relevant institutes

> **"that in order to avoid different decisions on the same disability matter consultations are performed between the systems before decision."**

3.4.3

An *accident disability pension* normally follows a year on daily allowances equivalent to one 360th of the person's annual earnings. The pension is granted if

> **"the injured person's loss of working capacity continues and is not less than 10% due to an injury caused by an employment accident or by an occupational disease and, in addition, that the reduction in his annual wage represents at least 5% of the minimum annual wage of the accident insurance. Disability is defined as incapacity to do the work done prior to injury or to do corresponding work, considering the injured person's age, place of residence, training and education, and the type of work available."**

For motor disability pension the definition of disability is identical. For all benefits, medical improvement and return to work must be reported.

3.4.4

In some ways the national disability pension acts in a similar fashion to the GDBA benefit in The Netherlands inasmuch as its basic component provides the underlying entitlement to which the employment disability pension adds an earnings related addition. Its scope is, however, far wider since all residents are covered, not only people disabled from birth but homemakers and others outside the labor market. The basic element, however, is small, only 307 Finnmarks a month whereas the means-tested supplement is 1436 FM, with further supplements for "helplessness" and variable housing allowances. Access to the employment disability pension is comparatively easy as a claimant need only have worked from one to four months depending on the program, compared with the five year minimum of many countries.

3.4.5

Rights to the accident disability pension are afforded to all employees and also to

> **"farmers, fishermen, and reindeer owners, including members of their families... and students working as trainees."**

Since these groups are included one might have expected the scheme to cover all self-employed people; the fact it does not is possibly due to the division of insurance between different institutes covering different sectors.

3.4.6

Rights under motor disability pension simply depend on the contingency of a traffic accident, although

> **"Drunken driving, gross contributory negligence and intentional causa-**

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tion of an accident places the driver outside the protection of the insurance. The same applies to an owner or holder of a vehicle who has failed to insure his vehicle."

Although motor disability insurance still retains much of the tort system from which it developed and everybody who suffers injuries is entitled to compensation, it appears that the disability pension is not awarded for loss of **potential** earnings, only for loss of **previous** earnings.

3.4.7

The actual calculation of the employment disability pension varies according to the particular scheme, but the maximum is 60% in the private sector and 66% in public service. The precise method of calculation is not given, but

> **"Under all laws, the pension of the insured person is determined by the length of his employment...and his earned pay."**

For accident disability pension length of employment is irrelevant and the amount for total disablement is 85% of annual earnings and for partial disablement 85% of the loss of earnings. Motor disability pension replaces lost earnings in full.

3.4.8

As in some other countries, but perhaps to a greater extent in Finland, these insurance programs are designed to provide a total package and not just earnings replacement. Both motor and accident insurance meet medical expenses as well as rehabilitation costs. Both too provide additional benefit for impairment as such, not dissimilar, apparently, to loss of faculty benefit which is the basis of the UK industrial injuries scheme. This is translated by the somewhat euphemistic term 'inconvenience allowance' in the accident scheme. Somewhat surprisingly this can be awarded as a lump sum; an example is given of a 20-year old in inconvenience class 20 receiving Finn-Marks 262,690.

3.4.9

Other benefits under the accident scheme include

> **"broken eyeglasses, hearing aids, dentures, and other similar appliances. Increased home management cost is yet another form of expenses under this category..."Inconvenience supplement...can also be paid to someone who... is not able to care for him or herself or who, owing to a serious injury or disease, suffers exceptional inconvenience. "Expenses arising from extraordinary wear of clothing as a result of the use of prostheses are indemnified under a separate category as are expenses arising from the use of a guide dog for the blind."**

3.4.10

The list of benefits under motor liability insurance includes

> **"medical expenses, pain and suffering, loss of earnings, disability pension, permanent handicap and disability, permanent cosmetic defacement, rehabilitation, funeral expenses and family pension."**

Apart from the apparent exclusion of potential earnings noted above, the list of benefits is as wide as most courts would award in a traditional action based on negligence. There seems to have been no 'trade off' for the no-fault and first party extensions, which not only extend the scope of the awards but ensure that the years of waiting for the law to take its course are avoided.

3.4.11

The *difference between* the motor accident program and the others is retained in the appeal process since after an agency review appeal is direct into the ordinary court system whereas appeals on other benefits go to the Insurance Court of Law. Only in motor accident cases is there a right to a face to face hearing but a claimant has to meet the costs unless his appeal is successful. Again it can be seen that the transition from tort compensation to social security is by no means complete.

3.5.1

In Israel the waiting period before disability pension can be awarded—three months—is very short. For all adults except "housewives" the criteria are

> **"1. He must be incapable of earning a living, or his capacity to earn a living by any employment or occupation must have been reduced in consequence of his disability by at least 50%.**
> **2. His medical disability must be at least 40%.**
> **3. His functional disability must be at least 50%"**

A housewife must have at least a 50% medical disability. She can escape this extra hurdle (and presumably the special assessment described below) if she has been employed or self-employed for 12 consecutive months, or 24 out of the previous 48 months before her claim. She is also treated as a single person if she has been separated from her husband for 24 months. Apart from this special provision for reclassification of housewives, there are said to be no eligibility requirements based on employment.

3.5.2

There are two stages in assessment.

> **"The medical disability criteria acts as a threshold. If a disabled person has at least a 40% medical disability, or a disabled housewife has at least a 50% medical disability, he or she has crossed the threshold and is entitled to evaluation with regard to vocational or earning disability."**

The claims officer will refer the claimant to a physican employed or authorised by the agency for assessment of the medical disability. For medical disability there are is detailed list of various medical conditions or impairments, subdivided by severity of condition, and subsequent percentage of medical disability to be allocated. It would appear that this is the less controversial part of the process since in 1983 of 4885 rejected claims only 687 (14%) were successful on appeal whereas out of 1959 rejected at the second hurdle, inability to earn, 1315 (67%) were successful.

3.5.3

If the threshold is crossed

> **"evaluation of loss or lack of capacity to earn...is done by the claims officer, on the basis of the medical evidence, other evidence and in about 60% of cases, the opinion of the rehabilitation officer of the agency." "In making his decision the claims officer will take into account the effect of the handicaps of the claimant on his ability to return to work on a fulltime or partial basis, and on his ability to carry out other kind of work or a new occupation which are suitable to his physical condition and state of health ...The claims officer will not take into account whether the claimant has had work proposed to him, or whether he did not fit into work."**

3.5.4

The level of disability pension is based on the percentage of functional disability:

"Degree of Disability	**% of the Full Benefit**
50-60%	**60%**
61-65%	**65%**
66-74%	**74%**
75+%	**100%**

Although 84% of recipients receive the full disability pension, the view is expressed that

> **"a proportionate disability benefit rating is a useful procedure providing for assistance to more disabled persons than would otherwise be the case."**

3.5.5

Although both employers and employees make contributions towards the cost of disability pensions, no contribution conditions are mentioned for receipt of benefit. Israel appears to have one of the most generous and egalitarian systems since people assessed at 100% receive benefit equivalent to the

> **"monthly average wage per employee post during the last three months for which there were data in the hands of the Central Bureau of Statistics."**

(There are also complex provisions relating to inflation.)

3.5.6

Since there are additional increments for spouse and children it is not difficult to understand that there are problems of incentives. These rates would appear far to outstrip any other non-contributory system and provide benefits only slightly below the maxima in countries with generous earnings-related schemes. Unfortunately, despite the clarity of the answer to the specific question on benefit calculations, it is elsewhere suggested that disability pension only equals 25% of the average wage and other sources suggest an even lower figure.

3.5.7

At each level there is a right of appeal and continued appeal. There is a feeling among many disabled persons

> **"that the present process is too long and wearisome."**

As in the UK, mobility and attendance allowances require further separate assessment processes which adds even more burden on the most severely disabled people. The view is expressed

> **"that the entire process could be simplified with all findings and decisions ...vested in one board, composed of experts in the fields of medicine, occupation and rehabilitation which would decide all relevant issues."**

3.5.8

The Israeli system is designed principally to award benefit for permanent disability, but there is provision for a temporary rating for from six months to two years.

> **"The utilisation of a temporary status of disability is considered a useful one... when we take into consideration that the outcome with regard to receiving disability benefits is dependent not only on the level of medical disability (which in itself can change with time, medication, or other medical treatment, and in relation to the natural history of the condition) but also and especially on the assessment of functional disability and inability to earn which is a much more flexible factor and often open to change depending upon psycho-social aspects, motivation, the state of the job market, and the utilisation of technological aids for the disabled person both in the home, and at work."**

13% of awards are temporary. In view of the above statement it is surprising that not only are permanent beneficiaries not required to submit regular medical evidence of continuing incapacity, they do not have to report improvement or even work undertaken.

3.5.9

The most well-known aspect of the Israeli disability benefit system is their unique method of assessing the functional disability of housewives. In brief, claimants attend special centres where they are tested on performance of a variety of domestic tasks. The view is expressed that any deliberate attempt to perform poorly during the test is balanced by the fact that the approach underestimates deterioration of capacity over time. Overall

> **"The impression is that the approach to providing disability benefits for a housewife is comprehensive, fairly clearly defined (in most cases) practical and reasonable."**

3.5.10

It would be interesting to know whether men in Israel would accept the same criteria. From the claimant's point of view a choice of the applicable test would be most satisfactory—and this is not wholly unreasonable considering that there is a prior medical disability hurdle. Alternatively, more flexibility could be incorporated (and even sex equality restored) by considering each case on its merits to decide whether, but for the disability, the claimant would be seeking paid employment. In the UK, however, this approach was rejected in favour of a more severe medical disability test and diminished emphasis on functional capacities.

3.5.11

Nevertheless the Israeli procedure may well have advantages missing in other systems.

> **"My impression is that with all its limitations, the evaluation is of use, and can provide a reasonable basis for determining, not only the level of functional disability, but in what areas there is a need for individual instruction or training or for a possible provision for a technical aid that can provide assistance."**

3.6.1

In Sweden, entitlement to sickness allowances or disability pensions is conditional on the

> **"working capacity of the insured being reduced by at least half as the result of illness. Sickness allowance is payable in cases where the reduction of work capacity will presumably be of limited duration or where its duration is hard to assess. If the reduction can be expected to persist for a considerable time, the insured can receive a temporary disability pension, while if it is expected to be permanent, a permanent disability pension can be awarded."**

Sickness allowance is income related and in principle can be paid for an unlimited period, unlike most countries. Even for the temporary disability pension, incapacity must be expected to last for at least a year which may explain the need for flexibility.

3.6.2

Population coverage is total.

> **"All nationals can receive a *basic* disability pension, regardless of work status, given reduced work capacity of at least 50%. There is also a *supplementary* pension for those with labor force experience which is based on employment time."**

No mention is made of any special tests for people outside the labor market, such as the housewives test in Israel. Indeed assessment appears to be based on the judgement of the assessors to a far greater extent than in some countries.

> **"Neither the National Insurance Act nor its traveaux preparatoires include any closer definition of illness for social insurance purposes. Accordingly, there is no list of illnesses qualifying for compensation. This has the advantage of facilitating flexible adjustment tothe effect of structural change on labor demand and also to the changing opinions of medical practitioners *and insured persons* concerning the states to be regarded as illness."** *(Editor's emphasis.)*

That final remark is not one that I would expect from many countries!

3.6.3

Pensions can be paid at rates of 50%, 66.6% and 100%, but no details are given of the numbers with a partial pension or whether they may be combined with earnings. The basic disability pension is flat rate and the supplementary pension is earnings-related.

3.6.4

Decisions on disability pensions are made at regional level by 'pension delegations'.

> **"Each pension delegation has eight members, the chairman and vice-chairman being appointed by the Government. Two physicians and two members with experience of working conditions are appointed by the National Social Insurance Board. Two members are appointed by the county council... or municipal council."**

Despite substantial lay representation by the standards of most countries, it is still felt that

> **"the professional authority of the physicians has inhibited the use by other members of their own judgement."**

Consequently there are proposals to replace the pension delegations by boards without any specific medical representation.

3.6.5

There is a simple appeal structure. In the first instance pension delegations may reconsider their decisions and there is further right of appeal to regional social insurance courts and to the Social Insurance Supreme Court. In both cases laymen participate in the decisions concerning permanent disability pensions. In 1984

> **"there were 47,000 applications for temporary and permanent disability pension, 45,000 of which resulted in full or partial pensions being awarded, while 2,000 applications were rejected. The social insurance services reconsidered about 1,500 cases, one third of which were taken to the regional social insurance courts. About one third of all permanent disability pension cases brought before the regional social insurance courts resulted in social insurance service decisions being amended."**

Altogether the success rate of applicants is high which may be a reflection on the increasing emphasis on economic factors as opposed to strict medical criteria.

3.7.1

Employees in The Netherlands are entitled to 12 months sickness benefit (SBA) of 75-100% of their regular earnings.

> **"One becomes eligible for the SBA when one is unable to perform one's work due to sickness on medical grounds...The trade associations are responsible for screening the legitimacy of the claims...Physicians and lay controllers employed by the trade associations carry out these screenings in the district offices. During this first year, it is almost solely the claimant's ability to do his own work which determines his or her rights."**

3.7.2

Since 1967 the SSDI equivalent—benefit under the Disablement Benefit Act (DIA) has been in effect an earnings related supplement to benefit payable on a broader basis under the General Disablement Benefit Act (GDBA). All residents in The Netherlands are eligible if they

> **"—have been disabled for a period of 52 consecutive weeks**
> **—are at least 25% disabled ...**
> **—have reached the age of 18**
> **—have earned wages in trade, industry or the liberal professions during the year immediately preceding the beginning of the disability.**
> **This income requirement does not apply to those handicapped since early youth."**

3.7.3

As in the United Kingdom there have been some problems over EEC directives in relation to married women.

> **"It is only since January 1980 that the married woman who is not separated from her husband also has the right to her own benefit, on the condition that she has become disabled on or after October 1, 1975 and meets the above-mentioned conditions."**

It would appear, however, that many married women might find the last condition difficult to meet. Since

> **"housewives and housefathers who have assumed responsibility for the care of children can receive no benefits, due to the requirement of annual minimum earnings..."**

The same exclusion applies to people who are not working because they are providing fulltime care for a disabled person.

3.7.4

The general basic rate of GDBA is 70% of the minimum wage and can be increased to 100% if the claimant's partner earns less than 15% of the minimum wage. There are seven rates of benefit ranging from 20% of the basic rate for 25% labor disability to 80% for 80-100% disability. The concept of labor disability is discussed below.

3.7.5

The GDBA also provides a wide range of services to beneficiaries and to people with disabilities who do not qualify for benefit—for example children under 18. These are described in section 5.

3.7.6

DIA benefits are based on the income which the employee loses as a result of disability.

> **"An individual standard (daily) wage is established for each insured person, based on that which he could have earned in his earlier employment had he not become disabled...The benefit is therefore a percentage of the daily wage. This percentage depends on the degree of labor disability."**

3.7.7

There is a maximum daily wage for the purposes of calculating benefit and and GDBA received is deducted from the total. The scale of benefit rates is different from GDBA, ranging from 9% of the daily wage for 15% disability to 70% for 80-100%.

3.7.8

Perhaps the most interesting aspect of the Dutch scheme is the concept of "labor disability" and the method of evaluating it. Its formal definition is as follows:

> **"Fully or partially disabled is he who, as a consequence of illness or impairment, is entirely or partially incapable of earning from performing work calculated on the basis of his powers and skills and which, in the light of his education and former profession, he can be expected to perform in all fairness, at that place where he last performed said work or a similar, nearby location, such wages as physically and mentally healthy persons of the same sort and with similar education do earn with this work in such locations."**

In perhaps a slight difference of emphasis from SSDI rules, labor disability is assumed to be present

> **"when, on the basis of medical grounds and medically demonstrable criteria, that work which is considered appropriate for the individual in the light of his education, powers and skills cannot be performed."**

3.7.9

Labour disability is assessed by the Joint Medical Service in three consecutive steps:

> **"1. The first things established are:**
> **(a) what non-disabled persons similar to the insured would earn (*the representative wage or income*);**
> **(b) what the insured, given the consequences of illness or impairment, could still earn through labor...(*the residual earning capacity*);"**

The degree of labor disability is calculated @ (a-b)/a and the person is placed on the appropriate point of the scale.

3.7.10

The second step is of key significance to people with disabilities in times of high unemployment. This step is called double evaluation. If someone is partially disabled (i.e., under 80%),

> **"2. When determining the degree of labor disability, the following factors, in so far as possible are to be taken into account:**
> **(a) The reduced possibilities for obtaining work due to this labor disability;**
> **(b) The newly obtained skills. The partially-disabled claimants who have not yet found employment are therefore given the benefit of the doubt and the failure to find employment is usually blamed on the labor disability. The result of this step is an increase in the labor disability percentage used for determining benefits to 80-100%."**

The third step in a proportion of cases is a review of this double evaluation after a fixed period of time. The precise details of the method of determining labor disability are too complex to be included in this overview, although aspects are included in the next section.

3.7.11

As will be seen, benefit decisions are only arrived at in The Netherlands after a very lengthy and thorough procedure. There are two complaints procedures: one within the JMS and one to the Social Insurance Council. The appeal system itself is fairly simple with Appeals Councils and a Central Appeals Council hearing appeals against the decision of the trade association on both medical and non-medical grounds. About 13% of appeals by claimants were successful in 1983.

3.7.12

As in all countries

"the social security system as a whole remains difficult for the insured to understand."

Nevertheless it appears to be fairly "user friendly" as the purpose of the procedures is a constructive one; the emphasis is not (as it may appear to claimants in some countries) on depriving people of benefits if the authorities possibly can.

3.7.13

There do, however, appear to be structural factors which may deter people with severe impairments from seeking work. The details of the gradation between benefit and earnings are described in the next section, but generally speaking no cash benefits are available to people with disabilities in full time work, although they will be eligible for the same range of services. For example the equivalent of "attendance allowance" payable in many countries is provided by enhancing the maximum benefit payable under DIA or GDBA to 100%; but the need for attendants and labor disability are two different things. This method of providing cash help for attendance also excludes people over 65 (although there are other programs.) Also, although cause of disability is theoretically irrelevant and there are none of the problems in deciding whether disability was caused by an industrial injury or not, the DIA program does exclude from benefit calculations disability which existed before someone became an "insured person" which parallels "pre-existing disorder" exclusions in industrial injury schemes.

3.7.14

In essence, therefore, The Netherlands presents a generous benefit scheme for employees no longer able to work or find work on account of disability with a reserve scheme which provides an adequate replacement income for those disabled from childhood and the self-employed. The non-employed, e.g., people caring for children, and the long term unemployed are not eligible, but there are other national schemes to ensure that no citizen is without an income which allows him or her not only to survive but to participate in society. Cash benefits for people with disabilities are however restricted to earnings replacement; broadly speaking the other needs of disabled people are met not through cash but through services.

3.8.1

Initial access to Invalidity Benefit in the UK has traditionally been very easy: simply the statement of the treating physician that the claimant should refrain from work. Until 1971 sickness benefit was simply paid without limit of time and the change of name and modest improvements introduced then did not alter the basic criteria. As elsewhere, during initial sickness a person is measured against the requirements of his existing job and after a period is expected to take alternative employment. Legally there is no formal requirement to operate the stricter criteria at a particular time and someone may always

> **"claim that his existing job is still available and it is not reasonable to expect him to obtain alternative work of which he is capable."**

In all the other countries studied the SSDI equivalent is a separate benefit and the important decisions are made on *application*. In the UK the equivalent evaluation of a person's capacity will take place on *review* of existing benefit entitlement. Access to Invalidity Benefit can simply be on the signature of the treating physician and—since it is really sickness benefit under another name—may be received for a single day; no prognosis of duration of incapacity is required.

3.8.3

This position may be in the process of administrative change. Until 1983, sickness benefit was paid for 28 weeks before conversion to Invalidity Benefit. Then, principally in order to avoid the tax advantages for people whose employers topped up their sickness benefit to full wages, Statutory Sick Pay was introduced for the first 8 weeks of initial sickness; this is paid by employers, is treated exactly as wages and is reimbursed by the Department of Health and Social Security. Since April 1986 Statutory Sick Pay has been payable for the full 28 weeks; and it is difficult to believe that the transfer direct to Invalidity Benefit will not be subject to more rigorous scrutiny by the DHSS.

3.8.4

Although many pressure groups have objected strongly to the switch to Statutory Sick Pay for employees (the unemployed and self-employed are still eligible for sickness benefit), the advantage for some people is that it is non-contributory and therefore payable to people excluded for one reason or another from the insurance scheme. Nevertheless, apart from the countries with no contribution conditions, access for young workers to the scheme is very easy—in 1985/6 earnings of £887 in one year sufficed. Benefits are also tilted in favour of people who become incapable of work at a early age as will be explained in Section 6.

3.8.5

The wording of the law—which has been developed by judicial interpretations—is similar to other countries; but far more emphasis is based on the judgement of incapacity than medical factors as such. A day of incapacity for work is defined as

> **"a day on which a person is, or is deemed in accordance with regulations to be, incapable of work by reason of some specific disease or bodily or mental disablement ('work' meaning work which the person can reasonably be expected to do)."**

The judicial definition of "work" is

> **"part-time or full-time work for which an employer would be willng to pay, or work as a self-employed person. To receive benefit you must show that, given your disabilities and work experience you are incapable of meeting the job requirements of an identifiable character of employment which is to be found in real life and is neither so remotely situated nor so rarely encountered as to put it outside the limits of practical contemplation."**

3.8.7

The elegance of the language should not be allowed to disguise the harshness of the criteria which are practically the same as the U.S. reference to any job within the national economy. Also, unlike most of the other European countries, there is no benefit for partial incapacity. Instead there is a "therapeutic earnings limit" which was originally designed to allow hospital patients to receive pocket money for work which was genuinely part of their therapy. Now anyone receiving Invalidity Benefit can take advantage of it with the agreement of their doctor and the DHSS; the limit is £26 which allows very modest part-time work, but the catch is that even earnings within this limit may persuade the DHSS that the person has demonstrated capacity for work within the definition cited above.

3.8.8

Under Beveridge's original proposals the effect of reclassification as "capable of work" would not have been the disaster it can prove today.

> **"Beveridge had argued that the needs of the long term unemployed and the long term sick were similar and he proposed therefore that the rates both for unemployment and for disability should continue without diminution so long as unemployment or disability lasts."**

In practice, however, someone who is reclassified may receive unemployment benefit at a significantly lower rate for 12 months and after that have no title to any income-replacement benefit other than the means-tested supplementary benefit. Since this has a capital limit of L3000, some disabled people may be left with no benefit at all.

3.8.9

The position of married women within the benefit system has been a longstanding blemish on the UK and almost all changes in their favour have been forced on the UK by the European Community (EEC). In addition to the gaps in contribution records that people caring for children are likely to have, until 1977 the historical view of married women as dependents of their husbands meant that they were allowed to opt out of paying more than a token insurance contribution if they did work and thus had no entitlement to Sickness or Invalidity Benefit. By the mid-1970s disabled married women were the largest group of people with no title at all to any benefit (at that time only their husbands could apply for means-tested benefits). When the Non-contributory Invalidity Pension was introduced primarily for people disabled from birth, the Government was determined not to pay it to all married women incapable of work who did not qualify for Invalidity Benefit; for in addition to the gross numbers, a far smaller proportion would have it offset against means-tested benefits since their husbands would be in work. Consequently the Government had to be forced to include married women at all; and the test applied to them was (a) incapacity for work *and* (b) incapacity for normal household duties.

3.8.10

This double test restricted the beneficiaries to around 40,000 out of over 200,000 who would have passed the incapacity for work test. A special test for married women, however, clearly was not in line with the European Community Directive on Equal Treatment in Social Security; so, in order to achieve the same result by other means, Non-contributory Invalidity Pension was converted into Severe Disablement Allowance for which the criteria are (a) incapacity for work and (b) *for people over 20,* 80% disability on the loss of faculty criteria used in the industrial injuries scheme. In practice this second criterion is the significant one, so this incapacity benefit is now adjudicated on purely medical grounds. Not too much significance should be made of this as the purpose is not to assess individual needs or abilities, but solely to restrict benefit payments and still comply with EEC law.

3.8.11

The appeal system in the UK is not the same for all benefits, but for Invalidity Benefit is first to a Social Security Appeal Tribunal (legal chairman and two lay members) and then to Social Security Commissioners. Since 1948 appeal to Social Security Commissioners has been possible on both facts and law, but the Social Security Act 1986 has restricted appeals to points of law. It is possible also to appeal further to the Court of Appeal and House of Lords. Matters within European law may be referred to the European Court in Luxembourg. Yet for reasons explained, appeals are usually about withdrawal of benefit, not the original award, and the significant factor is the review process which will be examined in the next section.

3.9.1

Although there are programs for benefits during initial sickness in all countries, there is no uniformity in the way they relate to the disability pension programs. The relationship may well be governed by the exact nature of the main program as well as whether the same institution has responsibility for both. Whereas in some countries the programs dovetail

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exactly (i.e., one converts to the other at a fixed point of time), in others there is an overlap, and in some there appears to be the possibility of a gap between the two.

3.9.2

The simplest link is in the UK where both benefits are part of the same program; sickness benefit simply becomes invalidity benefit after 28 weeks. The conversion in The Netherlands takes place at twelve months; in neither country is **prognosis** of the length of time the disability/incapacity will last a condition of receipt of the main benefit. All the other countries require such an assessment; benefit will not be paid unless the condition is likely to last, if not permanently, usually at least for six months or a year. Clearly there is the logical possibility of someone having exhausted his entitlement to sickness benefits, still being incapable of work, and yet not qualifying for the disability pension. Austria, the FRG and Sweden cope with the problem by having long and flexible periods of entitlement to sickness benefits—in Sweden's case indefinite. Assessment and award of disability pensions are not fixed to a particular date. In the FRG sickness benefit and semi-disablement pension can be paid at the same time; also a **fixed term** award of disablement pension is delayed for six months and presumably sickness benefit continues to be paid. In Finland the switch is after one year's receipt of sickness benefit when a prognosis of a further 12 months disability is required; it is not clear if people do fall into a gap. The gaps in Canada are very apparent since sickness benefit only lasts 15 weeks and eligibility for disability pension may take up to two years to establish. In Israel disability pension can be paid after 15 weeks; what benefit can be paid to people whose disability is not assessed as likely to last six months is not stated.

3.9.4

So, some countries just look back at previous incapacity; some just look into the future; and some look both forwards and backwards. The position of people with lengthy, but determinate, illnesses is not always clear. While all administrations wish to avoid elaborate assessments for incapacity which will only last a short time, individual claimants wish to have benefit security from some source whenever they are incapable of work. Any country which allows an individual to exhaust rights to sickness benefit and yet denies him disability pension solely on the grounds that it is not certain whether his incapacity will last a prescribed period, cannot be said to have a program which adequately meets the needs even of all insured workers.

3.9.5

Although the precise form of assessment for the main disability pension program could be said to be the crux of the study, it is by far the most difficult to analyze. Many of the countries, for example, refer to a reduction of 50% of earning capacity; but it is not possible just from legal formulations to determine whether this means exactly the same in practice in different countries.

Indeed some countries have slightly different definitions between separate programs.

3.9.6

The nature of the assessment often appears to be determined by whether the purpose is solely benefit adjudication, or whether it is designed in equal or greater part to assist rehabilitation and re-integration in employment. Most of the countries which indicate very close links between benefit adjudication and vocational rehabilitation, appear to give far more emphasis to functional criteria than to medical ones; any medical input is fully integrated with the assessment of ability to undertake particular tasks or even particular jobs. The exception is Israel which requires a 40% medical disability before a functional assessment can be undertaken. While all countries require inability to work to be related to some identifiable medical condition, there does not seem any reason to erect a medical hurdle if the rationale for the benefit is the inability to earn a living. The whole concept of a percentage medical disability is opaque anyway—what is the figure really supposed to tell us about the person? If it accepted that medical disability may not correlate at all closely with inability to earn a living it is by no means clear why someone whose 20% disability actually does prevent him working should be denied benefit. Certainly the programs which are based firmly on functional assessments appear far the most logical and impressive and would still do so even if they were not integrated with vocational rehabilitation.

3.9.7

Most of the European programs pay partial pensions for partial disability. Unfortunately often little information is given of how they work in practice. It has already been mentioned how partial pensions are increased to 100% in the FRG and The Netherlands for disabled people out of work, and it would have been interesting to know how they combine with other benefits or earnings in other countries. Both on economic and social grounds it must be right to encourage and enable disabled people who are only able to work part time to do so; countries which maintain an illogical absolute distinction between capacity and incapacity may well be forcing disabled people to exaggerate their disabilities in order to be assured of an income.

3.9.8

The treatment of married women is one of the most fascinating themes in the study; the variation is wider than for any other group. In many countries they have historically been seen as dependents of the husbands and in the UK, for example, they used to be allowed to opt out of the national insurance scheme even if they were in paid employment. Even if they do pay full contributions while working, many married women take long periods out of the labor market to care for children, or indeed for disabled relatives. Consequently their entitlement to disability pensions if they become sick or disabled at the wrong point in their lives may be jeopardised.

3.9.9

Some countries such as Austria, the FRG and Canada, make special provisions for people to remain fully insured, at least for short periods while giving birth or caring for young children. In The Netherlands people disabled from childhood are covered by the GDBA regardless of sex or marital status; but anyone disabled later in life must show recent connection with paid work. In Finland all citizens may qualify under the same rules for the national disability pension, but only a small proportion of this is not means-tested. Of the countries studied, only in Sweden is the inclusion of the entire population of working age included in the basic non means-tested disability pension without any apparent question or problem.

3.9.10

It appears that in every country except Sweden there is a strong likelihood that a disabled person who happens to be a married woman will receive less benefit than other disabled people. Since the emancipation of people with disabilities has, generally speaking, been following in the footsteps of the emancipation of women, one can expect this structural discrimination to come under increasing attack.

4. LINKS WITH VOCATIONAL REHABILITATION

4.1.1

In Austria the same body is usually responsible for paying for both benefits and rehabilitation and so there is a clear opportunity and incentive for the closest possible links.

> **"In the *pensions insurance*, vocational rehabilitation measures are normally financed by the competent insurance institute and the labor market service as both of them collaborate in their implementation. In the *accident insurance*, vocational rehabilitation measures are normally financed by the insurance institute... Co-operation with the labor market service is obligatorily prescribed by law."**

Access to vocational rehabilitation appears to be better organised under the latter program since

> **"early information of the beneficiaries on vocational rehabilitation is obligatory if they are undergoing medical treatment or rehabilitation in one of the insurance institute's own accident hospitals or rehabilitation centres."**

In pensions insurance, however

> **"normally a claim is necessary. In specific cases, the insured persons are informed of this possibility when making a claim for a pension."**

4.1.2

Nevertheless there are several opportunities for the identification of candidates for vocational rehabilitation within pensions insurance:

> **"—through reports by the health insurance institutes in cases of long sick leave periods.**
> **—during the decision making process on a pensions claim.**
> **—during medical rehabilitation measures.**
> **—during unemployment caused by a disability (report by the labor offices).**
> **—through reports from other rehabilitation organisations.**
> **—through a claim by the insured person."**

Vocational rehabilitation measures are offered if:

> **"—the disabled person is no longer able to exercise his last occupation or the one he learned and if medical rehabilitation measures did not show the required success or if a success cannot be expected from such measures.**
> **—incapacity to work or invalidity may occur in the near future.**
> **—the disabled person is qualified and inclined to undergo re-training.**
> **—vocational integration seems possible."**

Perhaps surprisingly for an integrated system, benefit cannot be denied if someone refuses vocational rehabilitation.

> **"rehabilitation measures can only be taken if the disabled person concerned agrees. The payment of benefits is independent of the implementation of vocational rehabilitation measures."**

4.1.3

While the view is expressed that the identification of candidates for vocational rehabilitation works well, the system of job finding **"is only exercised too scarcely."** This system includes a qualification test by vocational psychologists, trials of three weeks at a **"simultaneous workplace,"** school training with a diploma, as well as training, retraining and supplementary training at the workplace. Specific training may only be possible in certain cities. Nevertheless, positive results are claimed for the program as a whole for example

> **"in the fact that a great part of the wheelchair users return to work after vocational rehabilitation measures... Return to work is also achieved by internal changes in the company. Counselling and support by social workers, who also contact the employers, are of special importance."**

4.1.4

People in receipt of benefits appear to be treated generously if they attempt to return to work. Decisions are taken in each case taking into account the special circumstances. In pensions insurance

> **"a partial freeze of the pension will come into effect, if the beneficiary's income reaches a certain limit... If rehabilitation measures enable the beneficiary to return to work or if he/she has already been working for 36 months, the freeze amount becomes lower and thus the net pension increases."**

In accident insurance the assessed benefit is paid irrespective of earnings.

4.1.5

Relevant in the context of job opportunities for people with disabilities is the nature of the Austrian quota scheme (national policies which fix a percentage of employees with disabilities per firm or agency) which is double-edged, as in the Federal Republic of Germany. The quota is fixed at 4% for employers of over 25 workers.

> **"If they do not employ the prescribed number of disabled persons, they have to pay a penalty, if they employ more disabled persons than prescribed, they receive an award which is half the amount of the penalty."**

It is not stated how effective this carrot and stick method is. The profits are, however, used to provide loans and subsidies for the purchase or adaptation of cars and for adaptation of dwellings. Insurance institutes can also subsidise salaries during training with a company for up to four years. There is also the usual array of measures for adapting workplaces etc.

4.1.6

Despite what appear to be substantial incentives for both employer and disabled person,

> **"An increased unemployment rate certainly makes return to work more difficult for disabled persons. The special protection against dismissal and the additional holidays provided for in many collective agreements for disabled persons with a reduction of earning capacity of at least 50%, decrease the willingness of employers to employ disabled persons. Furthermore employers who are legally obliged to continue salary payments for certain sickleave periods fear that a disabled employee will be on sickleave more often than a non-disabled one."**

4.1.7

These objections deserve closer examination. If people with disabilities are seeking equality should extra holidays be a standard extra benefit? Of course if a disabled person can only work short hours, he should be enabled to do so; but the mechanism for coping with this appears to exist as described in para 4.1.4. Also the belief that people with disabilities have more time off sick than other workers has often been demonstrated to be unfounded. It would be helpful if national records distinguished between chronic sickness and disability in the employment context; the employer prejudice expressed here is a major hurdle to overcome and it needs to be systematically combatted in every country.

4.1.8

In summary, Austria appears to have a structure which is designed to provide the closest links between benefits and vocational rehabilitation aligned with generous financial incentives to encourage return to work. Nevertheless the overall level of unemployment, failure to make full use of retraining and employer resistance still present significant obstacles to the reintegration of disabled people into employment. It is also not fully clear whether all the same services are available to people with disabilities who have never become insured with an insurance institute.

4.2.1

In Canada there is a national program of vocational rehabilitation.

> **"These services and benefits are administered by the provinces and cost-shared by the federal government in order to enable disabled pesons to become capable of pursuing regularly a substantially gainful occupation."**

Nevertheless it is conceded that

> **"The system is not integrated with vocational rehabilitation; there is no formalized, routine referral process from the benefits program to vocational rehabilitation for those whose condition may improve, or for those not eligible for CPP because of the level of disability."**

4.2.2

No vocational criteria as such exist for CPP but, as elsewhere, age, education, work experience, and the general availability of work the claimant can perform are taken into account. The vocational criteria are assessed by

> **"a medical doctor within the Disability Determination section or any of the medical adjudicators. A vocational specialist has been used in the past, but not currently."**

Most of the section on agency linkage to vocational rehabilitation services is left unanswered since

> **"The CPP Administration is not involved in providing or sponsoring vocational rehabilitation services, although a trial period for return to work may be given. During this period the beneficiary may attempt a return to work without necessarily losing the benefit payment."**

4.2.3

The strictness of the criteria for CPP themselves militate against vocational rehabilitation.

> **"Vocational assessment is also confusing and discouraging to the client. To qualify for any federally funded program (VRDP), the person has to identify a vocational goal. If the individual's goal is to try to upgrade his or her abilities in order to become employable, the CPP benefit is in jeopardy."**

> **"Regular attendance at training programs are an indication of the ability to work, and progress is assessed over a period of time (usually 1-2 years)."**

Factors that influence ability of people with disabilities to obtain work are the high unemployment rate, regional and seasonal unemployment and the attitudes of employers. Employers may also be

> **"uninformed about assistive devices and worksite adaptations that would enable a handicapped person to do certain jobs."**

Vocational rehabilitation is nevertheless identified as a key element.

> **"Vocational rehabilitation is an important component of any benefit program. The vocational rehabilitation department at Queen's University assisted in developing a program for welfare recipients, and has had great success. When energy and resources are applied to vocational rehabilitation, we get results."**

4.2.4

The size of Canada and the distribution of population may make it impossible to operate a national system in the same way as a more compact country. Nevertheless the impression is given of a very impersonal process which must reinforce the structural disincentives towards rehabilitation. The re-evaluation of beneficiaries seems rather a hit and miss affair:

> **"a questionnaire is sent on a sample, or ad hoc, basis to test continuing eligibility. The claimant may be asked to provide further medical information on whether he or she has been able to find work."**

Beneficiaries whose entitlement is not thought likely to be permanent may be brought forward for reassessment at a specific time by the Determination Board which made the initial determination. Others are selected by a regular audit sampling procedure. The number of benefits terminated each year on account of recovery is fairly low—2%; this may be mainly due to the strictness of the criteria for original awards but does not suggest a high level of success in either monitoring or rehabilitation. Also, a random questionnaire is not the most humane way of reviewing eligibility; fate acting as it does, many must arrive when the claimant is dying. If it is necessary to conduct reviews at a distance it might be more effective to require the claimant's own doctor to submit periodic certificates to the effect that the person's condition had not improved.

4.3.1

The structural links with vocational rehabilitation in the Federal Republic of Germany appear to be as strong as they could possibly be.

> **"The various administrations that provide rehabilitation benefits are by legal mandate held to undertake early identification of service needs as well as speedy provision of the appropriate rehabilitation measures... Prior to as well as during and following medical rehabilitation services it is also examined whether vocational rehabilitation measures are indicated and feasible."**

4.3.2

Even within the context of social security a rehabilitation benefit is considered before either of the two benefits described previously.

> **"Rehabilitation benefits can be granted under pension insurance when earnings capacity is significantly endangered or already reduced due to illness/disability and when the rehabilitation measure is capable of substantially improving, or restoring, it and/or of preventing the onset of occupational/earning incapacity. The principle here is that rehabilitation comes before pension."**

The benefit paid to the individual is equivalent to sickness benefit. Assessment of vocational criteria prior to decision on rehabilitation measures usually involves an interdisciplinary team. Requirements profiles for the various occupations are available to the decision-making staff.

4.3.3

Vocational rehabilitation may be undertaken by a variety of agencies and it would appear that individual people with disabilities may risk being passed from one body to another before entitlement is established. Under the insurance schemes

> **"Rehabilitative measures are granted on condition that the insurant has paid in at least 6 obligatory contributions during the last 2 years or a total of 180 contributions. 60 contributions suffice in case of vocational invalidity or total disability or in case the insurant is threatened with (them) in the near future. Rehabilitation through vocational promotion is granted to insurants who have paid 180 contributions or who receive a pension because of vocational invalidity or total disability. Public servants have no claim to rehabilitative measures. Juveniles may claim rehabilitative measures after the payment of a single obligatory contribution on condition that it has been paid in within two years after termination of education."**

'Vocational invalidity' is presumably an alternative translation to 'occupational incapacity' giving entitlement to the semi-disablement pension. It does seem doubtful whether a contribution requirement for vocational rehabilitation and the consequent division of responsibility between multiple agencies is really efficient, let alone in the interests of individual disabled people. It would seem simpler and more effective for the insurance institutes to provide vocational rehabilitation for all disabled people with a general subsidy from government to cover the costs of the non-insured.

4.3.4

The rehabilitation provided though social insurance covers medical treatment and rehabilitation.

> **"Curative treatment—in particular in spas and other specialised establishments—including board and lodging is to be stressed in particular."**

Vocational rehabilitation is designed to integrate the insurant into working life.

> **"Measures which have to be taken into account are inclination, aptitude, and the former occupation of the insurant... Rehabilitation through vocational promotion includes support in regard to the preservation or procurement of a workplace (travelling expenses and removal), payment of integration allowance to the employer, vocational orientation, vocational preparation, adaptation and enlargement of vocational knowledge, training and vocational retraining."**

The scope of the vocational rehabilitation services is also wider than in most countries.

> **"Extended benefits also include examination fees, educational aids, work clothes, implements, the payment of assistance towards educational costs to the employer, travelling expenses, and even (if necessary) the procurement of a domestic help."**

4.3.5

Although the system described appears designed to ensure that no one obtains a pension before all the possibilities of vocational rehabilitation have been explored,

> **"Fundamental problems are present in respect to correct and early-enough application for benefits on the part of insured persons, so that the**

onset of occupational or earning incapacity could possibly be prevented by appropriate rehabilitative measures. The decision to apply may involve multiple factors; current experience also points to the fact that the employment situation is a major factor, with the numbers of applications made decreasing in times of reduced economic activity, so that there is a risk of insured persons in need of rehabilitation refraining from applying for benefits."

4.3.6

The existence of a semi-disablement pension should in theory reduce the disincentives to return to work, but it would appear that in time of high unemployment it is in the interest of recipients to have it converted to the full pension.

4.3.7

The quota scheme in the Federal Republic should also provide considerable incentive to employers to employ disabled people in addition to the specific help listed above under vocational rehabilitation measures.

> **"The provision of the Severely Disabled Persons Act oblige private but also public employers employing 16 or more people to fill 6% of their jobs with severely disabled persons. As long as the employers do not fulfill fully or in part their obligation to employ severely disabled persons, they have to pay a compensatory tax amounting to DM 100 per month, for each work place which should be, but which is in fact not, occupied by a severely disabled person."**

4.4.1

In Finland also the principle is

> **"Rather rehabilitation than disability benefits."**

at least for younger workers.

> **"In Employment Accident and Motor Liability insurance rehabilitation is considered a part of the compensation. The recipient of compensation has a subjective right to rehabilitation but, in earnings-related pension schemes rehabilitation is an extra benefit which is granted upon consideration."**

4.4.2

The conduit for rehabilitation is the Finnish member of Rehabilitation International, the Insurance Rehabilitation Agency, at least within the employment, accident and motor disability pension schemes. Rehabilitation is also administered by the Social Insurance Institute under the National Pensions Act and National Sickness Insurance Act. Under this program a person is normally referred for rehabilitation after receipt of sickness insurance daily allowance for 150 days when he is also advised to apply for the employment disability pension. The link between the two systems is not entirely clear. It is admitted that

> **"Referrals come to the Insurance Rehabilitation Agency on an average one year after the injury or onset of the illness. This time lapse is considered to be too long."**

It would appear, however, that under the ordinary employment program this delay is built into the system.

4.4.3

The functions of the Insurance Rehabilitation Agency are

"—to carry out vocational rehabilitation as a part of the insurance compensation stipulated in the legislation on employment accident insurance, motor third party liability, and employment pension insurance.

—to assist the insurance and employment pensions companies in the preparation, implementation, and uniformity of the rehabilitation programs."

No explanation is given of the restriction to "third party" liability in this context.

4.4.4

The Insurance Rehabilitation Agency does not provide services itself but uses existing services. Its role is the planning and management of the rehabilitation program. It employs 14 rehabilitation counsellors who are responsible

"for the management of the rehabilitation process from the opening of the case through the relevant stages and measures to the follow-up and closure of the case."

4.4.5

The success rate in the Social Insurance Institute is about 60% and in the Insurance Rehabilitation Agency 70-75%. Under all schemes benefit may be retained during work trial periods (the length depends on the circumstances) and the accident and motor vocational rehabilitation programs

"may provide full loss of earnings to the beneficiary for the needed period which may vary from a few months to a year."

Also,

"The state employment administration may reimburse the employer part of the salary for a certain period of time."

Nevertheless the disincentives are the same as in many countries.

"High benefits, high unemployment, adjustment to disability status, insecurity upon to return to work."

Part of the reason for the comparatively high success rate may lie in the selection of candidates for rehabilitation.

4.5.1

One of the special features of the Israeli system is that

"within and as an integral part of the National Insurance Institute there is an active rehabilitation department."

The department does not only deal with disabled persons, but within the disability benefit program its role is three-fold:

"1. Involvement in the assessment procedure for functional disability.

> **2. Provision of rehabilitation services.**
> **3. Activities of the Fund for Development of Services for Disabled Persons."**

4.5.2

The role of the rehabilitation officer in the benefit assessment has already been mentioned. The evaluation procedure

> **"is almost always a useful and required step for planning and providing individual rehabilitation services. Thus it most likely plays a dominant and useful role in moving the disabled person directly into rehabilitation and getting both sides motivated towards seeking a return to work as an important part of the program."**

Rehabilitation services can be provided by the rehabilitation officer to those claimants who have a 20-40% medical disability, even though they are not entitled to a disability pension. Since rehabilitation services are also available to "the unemployed" this 20% hurdle is presumably not as important as it might otherwise be. There appears slightly more coercion than in some countries since

> **"Those who do receive a disability pension are expected or required to go into a rehabilitation program provided by the rehabilitation department."**

4.5.3

The role of rehabilitation workers appears similar to that of rehabilitation counsellors in Finland.

> **"If after evaluation it is clear that the disabled person is unable to work at all, he or she will be referred to the welfare services. If there is a potential for work, either in sheltered or open employment, an individual program will be set up, and the rehabilitation department will take financial and organisational responsibility for the carrying out of work assessment, training, placement and follow through at the work place... After placement in open employment and continued employment for six months the disabled person is considered to be rehabilitated. If placement is unsuccessful, one to two further opportunities will be provided."**

4.5.4

The possibility of retaining disability pension during work trial periods in Israel is slightly unclear. At one point it is stated unequivocally

> **"The entire benefit is forfeited upon return to work."**

This is consistent with a statement in the monograph that

> **"Some rehabilitation workers believe that continuation of the disability benefits after the disabled person receives a salary from work would be beneficial and not detrimental, at least for a 'holding period' of 1-2 years, until the disabled person becomes well settled into a routine and has some satisfaction about holding a job."**

4.5.5

Considerable satisfaction is expressed with the work of the rehabilitation department.

> **"The close linkage and early involvement of the claimant in the rehabilita-**

tion process has definitely led to positive results, with beneficiaries returning to work."

Some impressive case histories are provided; but if success is measured by rates of return to work, Israel has no magic answer to global problems. As is predictable given the rate of disability pensions

" The most important disincentive is the low salary provided by work for unskilled or semi-skilled workers, as compared to the disability pension."

4.5.6

Unlike most other countries there appear to be few carrots and sticks with which to approach employers and this is seen as a weakness. The usual catalogue of prejudice on the part of employers is recited; and in addition the law makes it very difficult to dismiss anyone after a year's employment even if work has become unsatisfactory. There would certainly seem a good case for backing up the efforts of the rehabilitation department with some legal obligation on employers to hire people with disabilities. Yet it is evident that of all the countries studied Israel is by far the least homogeneous and it may well be that to institute a traditional quota scheme for people with disabilities would elicit pressures from other groups.

4.6.1

In Sweden rehabilitation measures are considered by the social insurance service while the person is receiving sickness allowance.

"The regulations...state that, in their day-to-day review of cases where insured persons have been receiving sickness allowance for 90 consecutive days, the insurance offices are to consider whether rehabilitation measures are called for."

The tasks of regional social insurance offices are:

"—To decide which persons should undergo rehabilitation (medical, social and vocational).
—To investigate the causes of work incapacity reduction.
—To ensure that suitable rehabilitation measures are organised as early as possible."

4.6.2

Rehabilitation inquiries are based primarily on data already available but further particulars can be obtained from the treating physician, social worker, vocational rehabilitation agencies, a social welfare authority, an employer or job adjustment group and other public agencies.

"The rehabilitation inquiry is aimed at charting those factors in the insured person's living situation which can affect his illness and working capacity and his possible rehabilitation. Accordingly, the inquiry must clarify the insured person's medical status and a social investigation has to be conducted. In connection with the social investigation, a working plan for subsequent rehabilitation has to be drawn up in consultation with the insured and in contact with the public agencies responsible for the activities included in the plan. At this stage of things the regional social insurance office frequently refers the matter to a local rehabilitation group."

4.6.3

These rehabilitation groups conduct comprehensive case conferences and would appear to be well placed to ensure effective co-ordination of services.

> **"These local rehabilitation groups exist to discuss cases involving several public agencies. Accordingly, they should only deal with cases of some complexity. In more straightforward cases, consultation should take the form of direct contacts between the authorities involved. Matters can be referred to the local rehabilitation groups at the instance of all parties represented in them. Within these local groups, agreement should be reached on a plan for the rehabilitation measures judged necessary and on the apportionment of responsibility for them. The plan is to be regarded as a contract between the insured person and the public agencies involved."**

4.6.4

Responsibility for the actual rehabilitation measures is mainly vested in:

—The Labour Market Administration (vocational rehabilitation).

—Municipal social services (social rehabilitation).

—The county councils (medical rehabilitation).

The emphasis on social rehabilitation is more marked than elsewhere; this may also be due to the broader concept on which disability pensions are now based and to recognition that unemployment may be due as much to social factors as to medical ones (not to mention economic ones).

4.6.5

Disability pension may be retained for trial periods varying from 2 weeks up to 3-4 months during on-the-job training.

> **"During a training period it is possible to return to normal employment part-time (with a commensurate salary) and receive (partial) benefits for the 'training part' of the day. This model can occur, for example, in an attempt to go from part-time to full-time."**

4.6.6

While the identification and referral system for rehabilitation is described as "fair", the obstacles to efficient rehabilitation are similar to other countries, although more emphasis is put on lack of resources than labor market conditions. The main obstacles are described as:

> **"—Lack of medical resources, with long waiting periods for examination and treatment.**
>
> **—The difficult employment situation and a shortage of suitable jobs for the partially employable.**
>
> **—Lack of resources in vocational rehabilitation, with long waiting periods and insufficent places.**
>
> **—On the part of insured persons, apathy and lack of motivation for rehabilitation.**
>
> **—Insufficient co-ordination of resources and different rehabilitation measures.**
>
> **—An acceleration of rejection processes. Persons with physical and/or mental defects cannot stand the pace of work. Symptoms develop which lead to sicklisting. —The persons, e.g. physicians, required to deal with these questions are insufficiently trained for the purpose."**

4.6.7

Once again a broad view of the situation is presented which is summarised as follows.

> **"These answers show that there are definite factors of inertia in the societal system which, in accordance with the model presented above, can be expected to prejudice the results of rehabilitation efforts."**

Greater efforts are now being made to maintain contact between the insured and his workplace.

> **"A certain amount of experimentation, involving a more detailed gradation of partial sickness allowance and a flexible arrangement of working hours has been sanctioned by the Riksdag and is now in progress in various local office districts."**

4.6.8

The level of benefits also acts as a disincentive, especially for elderly workers who may receive 85-90% of previous earnings when superannuation benefits are added to the basic and supplementary pensions.

> **"Summing up, new invalids encounter palpable threshold effects when entering the employment sector."**

4.7.1

In The Netherlands vocational assessment and guidance is an integral part of the benefit system. Indeed it is stated that

> **"the most important goal of the labor disability insurance schemes is the return to and maintenance or promotion of paid employment."**

4.7.2

The (JMS) teams which assess labor disability consist of a

> **"vocational rehabilitation expert, a national insurance practitioner (MD) and a legal assessor"**

The particular responsibilities of the vocational rehabilitation expert are:

"—in cooperation with the national insurance practitioner he must establish the chances of employment.
—investigate the labor possibilities among employers in the region.
—if necessary the vocational expert may call in specialists in the fields of training, the job market and facilities.
—initiating and designing—in consultation with the insured—a reintegration program.
—assisting the insured, in so far as possible, in obtaining employment.
—giving advice concerning living and labor facilities.
—providing labor facilities etc"

4.7.3

The medical practitioner first establishes the strain imposed each day by

"1. Exertion resulting from *maintaining the basal metabolism*
2. Exertion resulting from *daily personal care* (eating,drinking, bathing, etc.)
3. Exertion resulting from *leisure time activities*.
4. Exertion resulting from *work* performed"

A capacity pattern is established which indicates both the degree and frequency of strain in respect of each of 38 criteria. These same criteria are used by the vocational rehabilitation expert to evaluate local employment situations under the Employment Structures Documentation System.

4.7.4

Comprehensive information on both the claimant and local employment is therefore a pre-requisite for the benefit decision on which the JMS advises the relevant trade association. The JMS also is responsible for five additional forms of intervention

> **"A. *Preparation for (employment) mediation* is aimed at implementing measures intended to remove the obstacles which reduce the claimant's chances to actually return to the labor process. Included in this can be:**
> **—promoting the attainment of a final medical condition.**
> **—promoting optimal recovery (medical rehabilitation), obtained through rehabilitation.**
> **—learning to deal with the new situation (social rehabilitation).**
> **—re-training, learning new skills/abilities.**
> **—additional training, learning supplementary skills/abilities.**
> **—employment acclimatisation, (once again) gaining confidence in a working situation.**
> **B. *Employment counselling* (is designed) to find a position of employment or self-employment for the claimant. This entails:**
> **—aid to and supervision of the claimant in:**
> **—finding vacancies in functions and occupations suitable to him.**
> **—reacting to vacancies found, applying for the vacant functions.**
> **—the application interview and the procedure which follows.**
> **—researching the possibilities of establishment as self-employed, giving form to these possibilities.**
> **—aid to the claimant and employer in:**
> **—solving adaptational problems, aimed at the long term occupation of the desired function, within the context of the possibilities provided through the JMS (employment acclimatisation, initial salary, employment facilities)."**

The three other functions are assessment and provision of facilities and referral to other agencies. Although only employment aids and adaptations are particularly relevant here it is worth noting the advantages to people with disabilities of having a single agency assessing and providing equipment wherever it may be needed.

4.7.5

It was mentioned in the previous section in The Netherlands that people assessed at less than 80% disabled can have their awards increased to the maximum if they do not find employment, but that a proportion of those upgraded are reassessed after a period. These are people with the highest prima facie chances of obtaining employment: people under 45 who are able medically to do a full day's work and have sufficient expertise to perform employment that is available. If it is believed there is sufficient chance for the person to once again find employment a *re-integration plan* is set up. As well as formulating a program designed to re-insert the claimant in employment the plan is designed to discover whether the disability really is the cause of unemployment.

4.7.6

A number of general job market schemes can also be used by people with disabilities. They do not, however, seem to be of much assistance to them.

> **"The actual application of these general measures for strengthening the job-market position for the group of handicapped employees is quite low, at an average of between 4 and 5% of the total. In this way, the handicapped incur an increasing and relatively large position of disadvantage on the job market in comparison with other groups. The implementation of specific schemes in the context of the labor disability acts does not sufficiently compensate for this... The regional employment offices, whose job it is to supervise the employment mediation for all those seeking employment, have in recent years—unlike in the past—no longer implemented an active policy with regard to handicapped workers."**

4.7.7

One possible flaw in the program is that the vocational guidance, etc. only began at the time of DIA benefit claims; i.e., after someone had been off sick for 12 months.

> **"The trade associations and the JMS recently decided to begin makng a report of all claimants who have received sickness benefits for six months ... to the JMS. (Only such cases as will actually never regain sufficient functional potential and those who will quickly resume their own work are not included under this decision)... The claimant will therefore be screened for opportunities in the field of vocational rehabilitation as soon as possible after reporting to the JMS."**

4.7.8

With rising unemployment, success in re-establishing people in work has been declining year by year. In 1978 47% remained unemployed after the termination of reintegration activities, in 1983 the figure was 56%. It has been in particular increasingly difficult to find positions with new employers.

4.7.9

Benefits under DIA may be sufficiently attractive to deter people from returning to work. Benefit may, however, be retained for up to 18 months in order to

> **"remove the uncertainty for both the handicapped person and the employer concerning the durability of the employment."**

The total of wage and benefit may not, however, exceed 85% of the daily wage on which the benefit is calculated. Apart from this scheme, benefits based on less than 45% disability are normally adjusted after 52 weeks and those of 45% and above after the increased capacity for labor has lasted for four weeks.

4.7.10

The obstacles facing the employment of people in The Netherlands with disabilities are stated as

- the high rate of unemployment,
- characteristics of the groups as a whole such as age and low level of training or education,
- employer prejudice,
- higher pension premiums or even refusal to provide coverage,
- failure of employment regulations to promote reintegration,
- discouragement among the handicapped to continue after so many failures to apply for work,
- architectural barriers,
- general psychological resistance and prejudices in society,
- medical screenings by employers often do not correlate with specific functional requirements.

4.7.11

In summary, the institutional links between benefit assessment and vocational rehabilitation are about as strong as they could possibly be; but this is not sufficient to overcome the economic conditions. Most effort appears to be concentrated on younger, less disabled, people; and yet the success rate is less than 50%.

4.8.1

Although both medical care and social security in the UK are the responsibility of the Secretary of State for Social Services and vocational rehabilitation is provided by a Government agency, compared with other European countries the links between social security and either medical or vocational rehabilitation are practically non-existent. As has been mentioned, access to benefit originally depends solely on the signature of the treating physician; any subsequent medical assessment by a DHSS doctor is solely designed to confirm or deny continued eligibility under the stringent rules described in the previous section. Whereas assessments in other countries may involve a variety of professionals and take a matter or weeks rather than days, the verdict by the DHSS doctor on a person he may never have seen before takes an average of 24 minutes.

4.8.2

The review process may simply begin with a suggestion by the DHSS to the treating physician that he should stop signing his patient off work; if the treating physician stops signing sick notes it is almost impossible for someone to remain on benefit. The doctor may, however, either believe his patient is still incapable of work, or be unsure, or not wish to take the responsibility for benefit denial; in these cases he may agree (although his agreement is not necessary) for his patient to see a DHSS officer.

4.8.3

If the DHSS doctor says the claimant is capable of work, benefit will cease

unless the treating physician issues a fresh certificate. In order to succeed on **appeal**, the claimant must continue to receive certificates from his own doctor, although he will also have to sign on as available for work in order to receive unemployment benefit.

4.8.3

The argument against using treating physicians in social security is usually that they will not want to harm their relations with their patient by being responsible for loss of benefit. The British compromise is to have an obscure review procedure which is designed to encourage claimants simply to stop sending in sickness certificates and thereby avoid the necessity of a formal decision on benefit withdrawal; this also removes all rights of appeal.

4.8.4

Where other countries may automatically step in and provide both vocational rehabilitation and assistance to find work, the claimant in the UK is left largely to his own devices. One recent modest improvement is that a Commissioner's decision in 1985 now requires the DHSS to suggest alternative jobs the claimant might be able to do; if he can persuade a tribunal he is incapable of these he may win an appeal. Nevertheless the burden of proof lies entirely with the claimant.

4.8.5

Both vocational rehabilitation and assistance with obtaining employment is the responsibility of the Manpower Services Commission (MSC) which is a public body responsible to the Secretary of State for Employment. To encourage the use of rehabilitation facilities the MSC:

> **"(i) publicises rehabilitation facilities though their national network of Jobcentres.**
> **(ii) encourages registration for work, where from the information given needs can be identified. Furthermore, Disablement Resettlement Officers (DROs) based in Jobcentres are expected to maintain close links with hospital consultants and General Practitioners and to encourage them to refer patients who may benefit from rehabilitation/training. In addition to the 5 full-time Hospital Resettlement officers, 7 other DROs visit hospitals on a regular part-time basis, and others visit as and when the cases arise. 'The limited work procedure' is used by the DHSS to identify those incapacity benefit claimants who are considered fit for some kind of work, and these claimants are encouraged to contact the DRO if they need help with employment.**
> **(iii) provides for employers and hospital doctors or General Practitioners to recommend disabled employees or patients for courses of employment rehabilitation."**

An attempt is being made to improve these half-hearted links with the health service by establishing two experimental Employment Rehabilitation Units in hospitals.

4.8.6

If a disabled person does make contact with a DRO, he should be advised on the most suitable form of rehabilitation/training.

> **"Disabled people have to satisfy entry criteria applicable to each course run at Skillcentres and Colleges of Further Education. The MSC would not support a disabled person who would be unlikely to get work after training. In practice there tends to be an informal cut-off point based on age, which, though not always applied, tends to apply to all people irrespective of whether or not they are disabled, since generally employers are less willing to engage older workers.**
>
> **"The criteria for acceptance on courses of employment rehabilitation are that clients should be disabled, but considered likely to be capable of work after undergoing their course."**

4.8.7

It is easy to see how many disabled people, especially older people, can find themselves denied Invalidity benefits, be rejected for vocational rehabilitation, and have no prospects at all of ever working again. The only concession to some people in this position is that they may qualify for the higher rates of means-tested supplementary benefit payable to retirement pensioners and now automatically available from age 60 to both men and women.

4.8.8

The deficiencies of the "therapeutic earnings limit" have been descibed in the previous section; and indeed it is not intended by the DHSS to act as a work trial period. Until 1980, a person could return direct to Invalidity Benefit after up to 13 weeks in work (rather than to sickness benefit), but this has been reduced to 8 weeks. The whole structure is designed to encourage people to stay securely within the "incapable of work" category unless they can be absolutely certain of obtaining employment.

4.8.9

The UK has had a quota scheme since 1944. 3% of the workforce of any employer with 20 or more employees are supposed to be people registered as disabled with the Manpower Services Commission. While it is not an offence to be below quota (and there are no penalties as in the FRG or Austria) it is an offence for an employer who is below quota to hire a person who is not registered as disabled without a permit. Since permits are handed out in bulk on request and a substantial minority of employers fail even to ask for a permit, the law is of little practical use although organisations of people with disabilities do not want it to be abolished unless something better is put in its place. Only ten prosecutions have been by the MSC in forty years with a maximum fine of £100, which indicates that employers have little to fear. The emphasis of the Government is on persuasion and education and a Code of Practice has been widely distributed which is an excellent document but can do little on its own to counter the widespread discrimination particularly in relation to job applications and interviews faced by people with disabilities.

4.9.1

The countries with the closest links between benefit programs and vocational rehabilitation appear to have much in common. In particular a key feature is to have an overall plan and an identifiable individual in charge—in Finland and Israel the word "rehabilitation" is actually used in the person's title. In this way rehabilitation ceases to be a rather ill-defined optional extra appended to medical interventions but becomes the central focus of concern.

4.9.2

Little information was sought on **medical** rehabilitation in each country; in a few it is also part of the responsibility of the same agency which provides benefits and pays for vocational rehabilitation. In this way the logical progression is secured. In the UK, on the other hand, not only is vocational rehabilitation set on a distant limb far removed from the benefit program, medical rehabilitation itself has always been a "Cinderella" within the National Health Service, with a longstanding reluctance among the medical profession to decide whether individual consultants should be responsible for rehabilitation or whether there should be a separate specialty.

4.9.3

On the other hand in Austria and the FRG in particular, and possibly to a lesser extent in Finland, access to and the quality of vocational rehabilitation appears to depend on similar criteria to those used in the benefit program. For example, while it may be possible to justify higher benefits for work accident victims, it seems less acceptable to give certain groups priority in medical treatment and rehabilitation. To a certain extent the systems described would appear to be the "premier" service and not necessarily available to all people with disabilities who need them.

4.9.4

A number of countries have discovered a flaw in linking rehabilitation too closely to the benefit system for long term incapacity: if the assessment does not take place until after a twelve months qualifying period, the delay in providing rehabilitation may seriously decrease its chances of success. It is therefore advisable to commence rehabilitation during the sickness benefit period, especially if it is a lengthy one.

4.9.5

A continuing theme is the recognition that vocational rehabilitation must not be the last stage in the process; assistance with job placement is essential if the effort put into rehabilitation is not to be wasted. The Netherlands seems to integrate specific job evaluation most closely with benefit assessment, but a number of countries see the process of rehabilitation as continuing not until a person has obtained a job but until he is satisfactorily established in it. A variety of schemes are described whereby either the employer can be subsidised for an initial period, or the individual can retain either the whole or part of his benefit. In relation to incentives, the important principles are that there should be at least a modest increase in total income on a return to work, either full or part-time and that the individual can be secure in the knowledge that if the work trial fails his return to full benefit is assured.

4.9.6

The advantages of a partial benefit for people only capable of part-time work have already been discussed. In some countries the relationship between a partial benefit award and partial benefit retention during a work trial period is not entirely clear. For benefits which are designed to replace earnings, not to meet the extra costs of disability, there can be little reason to allow people to receive in total **more** than their previous earnings as seems to be possible in some places; complicated formulae for withdrawal of benefit may also lead to undesirable reductions in total income as earnings increase. During work trial periods the simplest policy would seem to be a guarantee of full salary; at the end of the period it should be known whether a permanent partial incapacity benefit is required.

4.9.7

Quota schemes must be the most discussed aspect of national policies in regard to people with disabilities and the limited information included does not provide many new insights. The evidence is that disabled people may find it reasonably easy to return to an employer who knows them and also (unless pushed into early retirement) can retain jobs as easily as anyone else. What is most difficult is obtaining a job with a new employer. Thought might therefore be given to switching the emphasis from percentages of the employer's total workforce which, in some systems, may lead employers to persuade existing employees to register as disabled; instead the significant factor could be the proportion of new recruits each year who are disabled.

5. SUPPORT SERVICES AND FACILITIES

5.1.1

The specific employment services in Austria have already been described; and mention has also been made of adaptations to cars and homes from the profits of the quota scheme. The provinces may also assist with adaptations to dwellings and provide subsidy under social assistance for the rents of people who need special care or, if necessary, for them to live in pensioners hostels or nursing homes. Provinces also provide subsidies for transport; e.g., to and from work, sports facilities, cultural events, physicians etc; and certain groups of disabled persons are entitled to reduced fares in trains and buses. Some also do not have to pay the basic telephone fee and radio and television fee.

5.1.2

In 1981 a *National Fund for Special Assistance to Disabled Persons* was created.

> ***"Benefits for medical, vocational and social rehabilitation can be granted, if no other possibilities of promotion exist and social hardship is given."***

No information is provided about the situation before 1981 and the impression is certainly given that people with disabilities who fall outside social insurance may fare less well. It has already been noted that social assistance does not confer legal rights. The social assistance of the provinces

> **"aims at helping those disabled persons that are not already taken care of by federal laws (social insurance etc) to achieve as good an integration or re-integration into society and into their working life as possible. Measures are medical treatment, provision of orthopaedic aids, help for vocational training and schooling, help through sheltered workshops, occupational therapy, personal help and granting of a care supplement. Furthermore, there is also help to secure daily living necessities and the social services such as home helpers, home nursing, cleaning services, laundry services, meals on wheels etc."**

5.2.1

In Canada, the Canada and Quebec Pension Plans have no responsibility for providing other services for people with disabilities and very little information is given of general services; mention has already been made of assistive devices and work site adaptations. Since, however, the disability pension stands on its own, no other benefits or services appear to be dependent on its receipt.

5.3.1

In the Federal Republic of Germany fairly extensive services can be provided by the pensions institutes in the name of vocational rehabilitation as has been described earlier. Non-insured people appear to receive a wide range of services under the 1974 Federal Social Assistance Act.

> **"Persons suffering from a substantial permanent physical, mental or psychological disability, or who are threatened by such a disability, are legally entitled to integration assistance, on the condition that they need it and that the individual financial situation warrants this public benefit. Integration assistance is intended to prevent the onset of disability, or eliminate or alleviate an existing disability or its consequences, and to integrate the disabled person into society."**

5.3.2

The criteria for the semi-disablement pension are used as a passport to a variety of benefits and services such as tax relief, free use of public transport, extra vacation, special protection against dismissal, but these

> **"are subject to controversial discussion in the Federal Republic, facing at present an amendment to the Severely Handicapped Persons Bill."**

5.4.1

There is little information from Finland on services which are not financed by one of the insurance programs, but these can be wide-ranging. The national disability pension program also provides universal coverage for sickness, medical expenses and transportation. Also

> **"Child care allowances are (given) for handicapped children under the age of 16 living at home who need substantially more care and rehabilitation than healthy children of the same age..."**

5.4.2

Vocational rehabilitation can include

> **"loans and other assistance to obtain tools and equipment for those setting themselves up in trades or business."**

The state employment administration may provide worksite adaptations or assistance at work. The accident and motor schemes may adapt a vehicle or provide interest free loans.

5.4.3

For children injured in traffic accidents

> **"basic education has to be part of rehabilitation. This means that if a child need special arrangements, e.g., transportation or equipment for his schooling, the costs will be covered by the insurance."**

Presumably, however, other disabled children have the costs met from some other source. Even under the general schemes

> **"on some occasions, especially for the most severe cases, basic education, e.g., secondary schools, has been understood as the preliminary phase of a vocational training program. In principle even studies at universities and other institutions of higher education are possible but because of the age and qualifications of the clientele this level of training is not very common."**

5.4.4

Unfortunately, since the emphasis of the data is on what particular institutions will pay for, it is difficult to build up an overall picture of facilities for people with disabilities in general. The impression is given, however, that the actual services are much the same for the entire population and that the elaborate structures are purely designed to allocate the costs. Since the underpinning provisions for uninsured disabled people are national and there are obvious interrelationships between the programs it is easier to believe that they receive roughly comparable services than in countries where programs for them are local and possibly means-tested.

5.5.1

As already mentioned, Israel has chosen to meet, through cash benefits, needs which other countries may meet through service provision.

> **"From April 1979, the law was extended to include provision of an attendance allowance or as it is called in Hebrew a 'special services allowance'."**

The purpose of the attendance allowance

> **"is not to act as a substitute for the various community services, but rather to be an additional support to the range of services dealing with the needs of a severely disabled person."**

Eligibility is restricted to people receiving a disability pension with at least 60% medical disability who are dependent on the help of others to perform everyday functions. Assessment is done

> **"through a visit to the home of a public health nurse who has been trained to do an objective evaluation with regard to activities of daily living of the disabled person...**
>
> **"A severely disabled person living alone with no family support framework receives a definite priority, as also a severely disabled person who requires supervision to the extent that a family member is required to be at home throughout the day."**

5.2

There are three levels of attendance allowance:

> **"A disabled person who requires assistance from another person in order to carry out *most* of the activities during *most* of the hours of the day, or requires constant supervision—is entitled to 50% of the full individual disability pension...**
>
> **A disabled person who is dependent upon another person for carrying out *all* daily activities for *most* hours of the day, is entitled to an attendance allowance equivalent to 100% of a full individual disability pension...**
>
> **A disabled person who is completely dependent for the carrying out of *all* daily activities for *all* hours of the day is entitled to an attendance allowance of 150% of the full individual disability pension..."**

For housewives the rates are reduced to 30%,60% and 100% on the (somewhat dubious) grounds that her disability pension is

> **"already an outcome of her inability to carry out her occupation as a housewife at home."**

5.5.3

Of more direct relevance to rehabilitation is the variety of help given with mobility. This is more important than in some countries since

> **"buses are very crowded and have no special facilities for physically disabled persons. The train service in Israel is very poor and also not accessible for disabled persons... Until very recently there was no public service run by a public agency providing acceptable transportation facilities for disabled persons."**

Mobility benefits are therefore concentrated on assistance with regard to buying and maintaining a car.

5.5.4

Although the National Insurance Institute handles benefit payments, assessment is performed separately by a medical committee of the Ministry of Health—a procedure considered burdensome and unfair by many disabled people. Benefits are available to people aged 3-65 with

> **"limited mobility, on account of disability in the lower limbs, according to a specified list of handicaps."**

This restriction causes many objections from people with disabilities other than of the lower limbs. Exactly the same complaints are heard in the

UK where the only difference is that some people with cardiac or respiratory conditions are eligible if walking would endanger their lives.

5.5.5

There are three categories of mobility benefit

1. *A Standing Loan*

This is given to offset the taxes on the purchase of a car. The percentage mobility limitation determines the percentage of the taxes covered. A driver needs 40% mobility limitation while a non-driver must have 60% mobility limitation, need daily transportation and have a 'relative' who drives for him.

A driver with 80-100% mobility limitation may receive a loan to cover the full tax on the model determined for him. A non-driver would only receive 75%.

2. *Mobility Allowance*

This is paid towards car maintainance expenses. For mobility allowance the threshold is 80% mobility limitation and the formula for calculating its size is very complicated. Of most significance is the fact that earners receive twice the amount of non-earners, (although non-earners with 100% mobility limitation who do not own a car receive the earners rate).

3. *Loan or Grant from Loan Fund*

This is even more restricted, requiring 100% mobility limitation; it is only available to an earner or someone in the process of rehabilitation who drives himself and is purchasing his first car.

5.5.6

A revealing insight into the way these complex rules affect individuals is given by a letter from a disabled person assessed at only 75% mobility limitation. Ineligible under the above rules, she approached a voluntary agency who said she could only be eligible for a loan for a car after two years of being employed. Since for her the only obstacle to employment was getting to work she describes this as "a classical 'Catch 22' situation!" With justice she complains

> **"A car represents to me the whole world as a substitute for my legs. With a car I can get a job to look after myself with dignity, without being dependent on the assistance and charity of various agencies who are supposed to be of assistance, and did not help me."**

5.5.7

The structure of mobility assistance in Israel does appear unduly complex and must incur significant bureaucratic costs.

5.5.8

Worksite adaptations can be funded by the National Insurance Institute and in some instances attendant help at work may be provided for a short period; but the Institute does sometimes seem to have its hands tied and to be unable to provide that last additional help the disabled person may need to establish himself in work.

5.6.1

Only a little information is included of the extensive network of services in Sweden for people with disabilities. In addition to disability pensions, further financial help is available to meet the extra costs of disability. For example there is the equivalent of an attendance allowance somewhat confusingly translated as disability benefit.

> **"Subject to certain conditions, the insured may be entitled to disability benefit. This benefit is payable to an insured who is at least 16 years old and whose functional capacity, before age 65, has been reduced for a considerable time and to such an extent that (a) he needs time-consuming assistance from another person in his everyday living,**
>
> **(b) he requires continuous assistance from another person in order to engage in economic activity, or**
>
> **(c) he otherwise incurs heavy additional expense.**

5.6.2

Compensation for extra handicap-related expenses cannot exceed 65% of the amount of the basic disability pension; but help is available whether or not someone is working or in receipt of pension. There is also a variety of help with transport.

> **"This can take the form of a certain number of taxi or handicap-bus tickets provided by the local community, and in some instances monetary compensation, e.g. for treatment trips to hospital."**

5.6.3

There is also practical help to enable people to take up work including worksite adaptations by the Swedish Labour Market Board, an adapted car for getting to work and, as noted above, a benefit to meet the costs of assistance at work. In addition

> **"the present law requires all employers with more than 50 employees to create an 'adaptation group'. The group consists of representatives from the employer, the unions and the local employment agency. In principle, these employers are required by law to attempt to employ a small number of persons with various handicaps."**

5.7.1

In The Netherlands, for recipients of DIA or GDBA and other non-insured people under pension age, such as children, as well as people with disabilities in employment, a wide range of services and facilities are provided by the JMS, as has been mentioned in previous sections. Although the equipment, for example, may be identical, help is provided under two headings, employment facilities and living facilities. The criteria for the former are less stringent.

> **"An *employment facility* exists for the purposes of increasing, restoring to its former level or maintenance of the (residual) earning capacity of the claimant. This can involve a position in which the claimant could poten-**

tially (for example after retraining) or actually (for example, after adaptation of the place of work) be placed. A *living facility* is a facility aimed at compensating, in so far as possible, for a handicap resulting from illness or impairment in the daily living operations of the handicapped.''

Living facilities must be aimed at one of the following

- **''transport within the home**
- **outside transport**
- **the dwelling**
- **activities of daily life**
- **communication**
- **relaxation or development, in so far as these apply to the adaptation of devices or specific devices or when non-provision would lead to critical deprivation or psychological decompensation.**
- **repair, replacement, maintenance and laundering of clothing and bedding.''**

5.7.2

There is also a variety of other programs run by government departments, local authorities and the health insurance funds. Some of these are special schemes for funding day centres or cluster homes, others are of more general application such as the funding of home helps by trade associations, the provision of parking facilities, and the subsidisation of adaptations to housing.

5.7.3

In summary the possibility exists in The Netherlands of obtaining almost any type of aid or facility a disabled person needs and to a large extent these are provided by the same body that assesses benefit entitlement. Nevertheless the structure and the absence of statutory rights to particular services may both limit the choice of people with disabilities and render the services liable to severe contraction if a Government is looking for reductions in public expenditure as will be seen in section 7.

5.8.1

One of the perennial discussions in the UK has been whether the needs of people with disabilities are best met through ''cash'' or ''care''. Organisations of physically disabled people have put the main emphasis on cash benefits; those representing the families of people with a mental handicap or suffering from mental illness have always been more concerned with the quality of services. Somewhat inevitably the result has been a mixture of the two. As well as giving more choice, cash benefits can also be administered with reasonable uniformity throughout the country. Services which are the responsibility of independent local authorities will inevitably vary; and in the UK the variation has been unacceptably wide.

5.8.2

As mentioned in section 2 there are two universal, non-means-tested, non-contributory tax-free cash benefits which are designed to offset in part the extras costs of disability. The first to be introduced was attendance allowance which was modelled on a similar benefit paid within the industrial injuries scheme. The medical conditions for attendance allowance are that

> **"you must be so severely disabled, physically or mentally, that you require from another person:**
>
> **During the day: frequent attention throughout the day in connection with your bodily functions (e.g., going to the toilet, washing or eating) *or* continual supervision throughout the day in order to avoid substantial danger to yourself or others.**
>
> **During the night: prolonged or repeated attention during the night in connection with your bodily functions or continual supervision throughout the night in order to avoid substantial danger to yourself or others."**

The allowance is paid at two rates depending on whether both or only one of the day and night conditions are satisfied.

5.8.3

Attendance allowance is paid to anyone over 2 who is not being supported by public funds in hospital or residential care (the needs of disabled children are also compared with those of able-bodied children of the same age). A substantial proportion of recipients are very old so the scheme is in this respect significantly different from those in Israel or Sweden or those linked to insurance schemes for people of working age. The main criticisms of the allowance concern its administration since assessment is by a DHSS doctor after a brief visit with the decision made by another DHSS doctor in a national office.

5.8.4

There is an extremely high success rate on review.

> **"In 1984 56% of "appeals" against total denial of attendance allowance were successful and 77% of "appeals" against award of only the lower rate... The DHSS usually claims that the high success rate on reviews is a result of deterioration between the two examinations. It is apparent, however, that far more care is taken over reviews than over initial determinations."**

While the rates of attendance allowance are insufficient to purchase a significant amount of paid care, it does prove an invaluable addition to the income of families caring for a severely disabled member.

5.8.5

Since 1975, someone caring for a person receiving attendance allowance has been eligible for an Invalid Care Allowance unless they were already receiving another state benefit (e.g., retirement pension) or their spouse was receiving an addition for them to their benefit (e.g., invalidity benefit). Someone receiving Invalid Care Allowance does, however, receive national insurance credits which protect their right to both retirement pension and sickness, unemployment and invalidity benefits.

5.8.6

The most effective cash benefit in the UK is the mobility allowance which was introduced in 1976. (Until then the DHSS issued rather unpleasant single seater invalid tricycles to some disabled people who could drive themselves. Apart from the inherent defects of the "trikes", the Government came under increasing pressure from "disabled passengers" who were unable to drive.) Rather than issue cars to everybody, it was decided to switch to a cash benefit payable to people unable or virtually unable to walk. Soon afterwards a charity was established (called "Motability") through which beneficiaries are able to lease or buy cars at favourable rates.

5.8.7

While some groups with mobility problems, such as people with visual or mental handicaps, have complained consistently about the criteria, the major quarrel has been over the restriction to people under pension age. In the original Act men would have lost their mobility allowance at age 65 and women at 60, but as the 60-65 age group were due to be phased in, the Government saw storms ahead both from the equal rights lobby and also from people who were given the allowance one week and had it removed a few months later. So the law was changed to allow women to be awarded it up to age 65 and all recipients to retain it until age 75. The first 75 year olds will lose their allowance in autumn 1989 and few political observers doubt that there will be another change in the law shortly before that date.

Mobility allowance has undoubtedly contributed significantly to the emancipation of people with physical disabilities over the last ten years; the ability to travel is an indispensible prerequisite of participation in society.

5.8.8

Service provision is mainly the responsiblity of the National Health Service or of local authorities. The most significant advance came through the Chronically Sick and Disabled Persons Act of 1970. This Act requires local authorities to assess the needs of disabled people for a variety of services and gives them a legal duty to make arrangements for what they consider each individual disabled person needs. Unfortunately this legal duty has been proved almost unenforceable, despite immense efforts by voluntary organizations. The Disabled Persons (Services, Consultation and Representation) Act 1986 is meant to strengthen the role of people with disabilities in the assessment of their own needs, and make it more difficult for local authorities to evade their duties.

5.8.9

Specifically in relation to employment, similar help is provided by the Manpower Services Commission to that in other countries—special equipment, adaptations etc. There is also a "Fares to Work" scheme which can assist people whether or not they receive a mobility allowance.

5.9.1

The data on services for people with disabilities varies considerably between countries because some gave very little information on assistance not provided by the agencies responsible for disability pensions. Despite this, provisions in some countries have been described fairly fully since a number of general issues arise. The benefits or services described here are designed to meet the extra costs of disability and the first question is whether it is necessary or desirable for these to be linked to the main disability pension program. We see the potential advantages in The Netherlands where the same agency can undertake a comprehensive assessment and is able to provide necessary equipment etc. regardless of whether it is needed at home, school or work; for people of working age, rights to services are not linked to rights to benefit so any potential discrimination in this regard is overcome.

5.9.2

In Finland we have seen that particular funds can be responsible for paying for a wide range of services in particular circumstances with some doubt as to whether other disabled people have the same services paid for from another source; in other countries with disability pensions based on insurance institutes there is usually more emphasis on services related to vocational rehabilitation and return to employment. In many countries, the majority of people with disabilities (if the elderly are included) would appear to depend on local services which may be discretionary, means-tested and uncertain. From the point of view of the individual citizen who needs a service, the important factor is obtaining it quickly and efficiently regardless of his status or place of residence. There would, however, seem to be scope for just as much discrimination between people with disabilities in respect of services as we have seen in relation to benefit programs themselves.

5.9.3

This discrimination is likely to become increasingly criticised in relation to provisions for elderly disabled people. In the countries studied the percentage of elderly people is increasing steadily and within this group there is a growing number of severely disabled very old people. For some, institutional care may be appropriate, but many will wish to continue living in their own homes with or without the support of relatives. Do these people have the same rights to make their own choices that younger people with disabilities have been demanding and achieving in recent years?

5.9.4

A related factor is retirement in what now must be described as late middle age, not old age. Pensioners are becoming a major political force in many countries and those who become disabled in their sixties and seventies may have the same expectations as people in their forties and fifties and not accept inferior treatment.

5.9.5

Because the situation is more clear cut, this issue may come to a head sooner in countries which have chosen to put more emphasis on providing cash benefits with which disabled people can purchase the services they want. On balance, cash benefits have two overwhelming advantages: they can be provided uniformly across a country and, even if they are used to purchase services from a public body, they give more power to individual disabled people—in other words they are changed from clients into consumers.

6. PEOPLE DISABLED AT AN EARLY AGE AND WORKERS WHO BECOME DISABLED IN THEIR FIFTIES.

6.1.1

As has been noted, people in Austria who are not insured are the responsibility of Social Assistance provided by the provinces about which comparatively little information is provided. In addition

> **"—The employment service within the Labour Promotion Act is entitled to promote disabled individuals who have never worked in their efforts towards achieving employment or possibilities of vocational training.**
> **—According to the Invalid Employment Act, disabled children as of the 15th year of age can be supported.**
> **—The National Fund for Disabled Persons can undertake promotional measures for all disabled persons independently of their position in the production process."**

6.1.2

As in many countries young workers are assisted to become fully insured at an early stage. Insured persons of under 21 years of age only require 6 months insurance before they are eligible for benefits.

6.1.3

The position of older workers is more complicated and the reasons behind the policy are not fully explained. It appears that the contribution conditions become more strict while the medical and vocational requirements are loosened.

> **"If the claimant has reached a certain age (men 55 years, women 50 years), the waiting time of 60 months insurance coverage increases by 1 month of insurance coverage for each further month after having reached that age. The frame of time of 120 months increases by 2 months for each further month... For 1985, the waiting time is limited to a maximum of 96 months ...within the last 192 months.:"**

This rule would appear to be designed to prevent people who return to work in later life from obtaining insurance coverage too easily. Once insured, the road to benefit is made easier since insured persons over the age of 55 only have their own previous employment taken into account.

6.1.4

As noted in para 2.1.3, parents can receive increased family allowance for disabled children up to the age of 27.

6.2.1

In Canada people with disabilities who have never worked are dependent on Provincial Family Benefits. No mention is made of modifications to the contribution conditions for CPP to assist young workers; it appears that five years employment is necessary for them in order to become insured.

6.2.2

Neither is there any general mitigation of the medical criteria for older workers as is seen in some other countries. Under the Quebec Pension Plan, however, since January 1984

> **"a person between 60 and 65 years of age unable to perform his or her *usual* occupation is now eligible for benefits, rather than having to show inability in *any* gainful employment."**

6.3.1

In the Federal Republic people disabled from birth are the responsibility of the Federal Social Assistance Act, not social insurance, and there is no information on which to compare the quality of service. There also does not appear to be any special mitigation of contribution conditions to help young workers to become insured for pensions; but vocational rehabilitation measures are available on the basis of a single contribution within two years of completing education.

6.3.2

No special rules or arrangements are noted for older workers, although as in all countries, age and experience are part of the assessment criteria. Since the size of disablement pension is directly related to length of insurance, older workers may well see advantages in obtaining and retaining benefit.

6.4.1

In Finland people disabled from birth or childhood are covered by the national disability pension and it has been noted that vocational rehabilitation may even cover secondary education. Access to the employment disability pension scheme also only requires up to four months employment so young people in general appear to have little difficulty in entering the "system."

6.4.2

At the other end of the age range the situation is rather different. Despite the stated priority given to rehabilitation and the rights under the accident and motor schemes,

> **"As a rule, no person over 50 years of age should be referred for rehabilitation unless there are exceptional factors in favour."**

From the age of 55 someone who has been unemployed for a long period is eligible for an unemployment pension which appears to be equivalent to the national disability pension. In the private sector where the pension age is 65 it is possible to receive a reduced pension from the age of 60; unlike some other countries the pension appears to revert to the full rate at 65. Overall, it would therefore appear as if the policy in Finland is to concentrate rehabilitation on younger people and make access to benefits easier for people approaching retirement age.

6.5.1

The lack of any prior work condition for receipt of disability pension in Israel means that people disabled from birth or childhood are treated with greater equality than in any other country. Moreover, included in the general disability benefit program from the age of 3 is a disabled child

> **"who as a result of any physical, mental or intellectual impairment, is significantly dependent on others for performing everyday functions."**

The benefit is, however, subject to a means test on the parents' income and cannot be paid in addition to mobility allowance.

6.5.2

The assessment of disability in children follows the same procedures as for adults, although it is recognised that assessing the functional disability of a child is more difficult and less precise. Benefit can be paid at 5 rates equivalent to 30%, 50%, 70%, 100% and 120% of the full pension for a single person.

6.5.3

Families with a disabled child in Israel may also receive a variety of help from several sources, such as

> **"a 50% reduction in cost of installation of a telephone, 50% reduction in monthly telephone maintainance costs, and 60 free telephone calls a month. There are other benefits available from the Ministry of Health, and from the Ministry of Education, and Ministry of Welfare and a reduction in income tax from the Ministry of Finance. It is pointed out by social workers that each ministerial department has its own demands, bureaucratic rules of procedure, and that the harassed parent travels from pillar to post to get all these possible benefits. More centralisation, or at least standardisation of procedures, would be useful and cost-saving both for the governmental agencies and for families."**

No doubt the same cry arises around the world and perhaps standardisation is the holy grail. At least with uncoordinated systems the persistent claimant is likely to receive some rewards for his efforts from some quarter, while a standard and simplified approach may simplify some disabled people out altogether (a current refrain in the UK). That said, for children in particular, to have two agencies providing cash benefits (disability pension and mobility allowance), one means-tested , one not, which cannot both be paid together seems unduly burdensome. In view of the complex calculation of mobility allowance it would seem likely that parents might not know which benefit it was most valuable to claim and would therefore subject their child to both assessments.

6.5.4

There is far less information on the position of older workers in Israel. There would not, however, appear to be any greater structural disincentives within the benefit system for older than younger workers, nor any policy to make it easier for them to qualify for benefit and to concentrate rehabilitation on younger workers. One consequence of the cash approach to disability is that on purely medical and functional criteria elderly people are likely to become the bulk of the recipients. This has straightforward implications in cash terms for governments who may feel, for example, **from the point of view of the national economy** that a mobility allowance for someone of 90 is of less value than for someone of 30. As we have seen, Israel tilts mobility help towards people in employment and this is common in other countries on economic rather than social grounds. In any democracy, however, one of the most difficult things to do is withdraw a benefit from someone; and in Israel

> **"if the disabled person is receiving special allowances such as mobility or attendent allowances he or she will continue to receive these allowances after reaching retirement age."**

6.6.1

There is little mention of help for disabled children in Sweden, but an unspecified benefit is paid to parents who take care of a disabled child under 16 years of age. As mentioned earlier the absence of contribution conditions means that from the age of 16 a disabled person can qualify for the basic disability pension.

6.6.2

The treatment of older workers is of particular interest. Until 1970 the criteria for disability pension were functional and similar to those of many other countries. Representations from the Swedish Trade Union Confederation suggested that

> **"structural changes in industry, together with technical and organisational development in enterprise, had created problems of unemployment and adjustment at work for many elderly employees. (It) therefore took the view that security benefits were needed for these elderly workers."**

More emphasis was placed on employment considerations and less on medical aspects, although

> **"work capacity would still have to be affected by a certain 'non-trivial' medical factor. The previous concept of 'disability' was also expanded by making age changes sufficient grounds for the award of permanent disability pensions to insured persons who had been worn out by physically heavy or mentally strenuous work and had difficulty in keeping up with the pace of work."**

6.6.3

The age of 63 was the benchmark for defining "elderly workers." Their work capacity was to be assessed

> **"with reference to their prospects of continuing to gain a livelihood through work which they had done previously or from other suitable employment.**
>
> **"This also meant that elderly insured persons would not be required to submit to rehabilitation measures or to relocation in areas with better employment prospects. This, however, did not mean an absolutely free choice between employment and pension. If the labor market authorities were able, within a reasonably short time, to find the insured a suitable job which did not require any retraining, his pension entitlement had to be assessed as if he had accepted that job. Otherwise, though, assessment was to be uninfluenced by any non-utilised residual work capacity."**

6.6.4

At this stage the provisions were similar to those current in other countries which relax the rules for elderly workers. The reform was, however, short-lived as only two years later the Minister of Health and Social Affairs felt

> **"that allowance must be made for the possibility of elderly workers becoming permanently unemployed even with physical or mental capacity unimpaired. A person in this position could be said, just as well as a person awarded a permanent disability pension under the current regulations, to have left the labor market once and for all.**
>
> **"It was therefore proposed in the Government Bill that elderly persons in this position whose unemployment insurance coverage had expired should, for reasons of social policy, be made eligible for permanent disability pensions on employment grounds, without any special medical assessment."**

Consequently, claims from people aged 60 or more are not even referred to the pension delegations referred to in Section 3.

6.6.5

There seems to be some ambivalence in Sweden about the virtue of these changes. A *Retiring Age Committee* found that

> **" permanent disability pensions had evolved from sickness and disability pensions to an individualised pension for persons most in need of flexible retirement age for medical or employment reasons. The Committee had come to the conclusion that the wider scheme of permanent disability pension had acquired considerable importance, and it recommended that this scheme be made an essential part of a flexible retirement age system, above all for insured persons aged between 60 and 65."**

On the other hand the view is expressed that the changes have allowed unions and employers associations on a consensus basis

> **"to apply permanent disability pensions to situations for which it was not intended. One also finds that there has been a steep increase in the number of permanent disability pensions awarded to persons between the ages of 45 and 60, which might be taken as a 'spin-off' from the more lenient medical assessment applied concerning reduced working capacity among elderly workers."**

A Parliamentary Committee was appointed to review the pensions systems and the rules applying to flexible retirement age.

6.7.1

The position in The Netherlands of people disabled from childhood has been largely covered in previous sections. Those disabled before the age of 17 can draw GDBA benefits from age 18, and the range of services described in section 5 is available to all children with disabilities. The data did not indicate whether there are special efforts made by the JMS to habilitate and find employment for this group although, as has been seen, extra effort is concentrated on younger age groups and those with most prospects of employment.

6.7.2

Conversely least effort seems to be made to re-introduce older beneficiaries to employment. As seen in para 4.7.5, ''re-integration plans'' are aimed at people under 45.

> **"Labour disability programs also had a vacuum-like effect, as many employers rid themselves of the less-productive workers by allowing them to enter disability programs."**

It is easy to see how the DIA program could degenerate into an early retirement program in current circumstances. Unlike some countries where such a policy is more explicitly accepted, benefits under DIA are significantly higher than the flat rate pension to which they automatically convert at 65. The policy decision appears to have been to establish equity between disabled people and their contemporaries in work rather than between people without employment owing to sickness, disability or age—(although the prevalance of private pensions would need to be taken into account). In general it is fair to say that in The Netherlands provisions for people with disabilities below pension age are significantly better than for those above it.

6.8.1

In the UK recognition within social security of people disabled from birth or childhood did not really come until the introduction of non-contributory benefits in the 1970s which have been described in previous sections. After the change described in section 3.8.10 people aged 16-20 who have been incapable of work for six months became eligible for Severe Disablement Allowance without having to pass the ''80% test'' on the scale used in the Industrial Injuries Scheme. The Allowance is, however, so low that almost all will qualify for supplementary benefit.

6.8.2

Yet qualification for the national insurance benefit, Invalidity Benefit, was shown in para 3.8.4 to be comparatively easy. The structure of the benefit is also designed to give more to people disabled at an early age in order to compensate them for decreased opportunity to build up assets. The addition to the basic Invalidity Pension, Invalidity Allowance, was introduced six years before the earnings-related addition became payable so it was not originally intended as a substitute for a lower pension. Since 1986, however, Invalidity Allowance is only payable to the extent that it exceeds any entitlement to the earnings-related addition, which suggests its raison d'être has changed.

6.8.3

For single people who first qualify for benefit when they are under 40, Invalidity Allowance increases their pension by 21%; if aged 40-50 by 13%; if aged 50-60 (men) or 50-55 (women) by 7%. Once awarded, the rate is continued so long as incapacity lasts and is also paid with retirement pension. One defect is that if someone on the highest rate attempts to go back to work after he has passed the age of 40 and works for 8 weeks he can only ever requalify at the middle or lower rate; this obviously can act as a disincentive.

6.8.4

The only benefits for disabled children are attendance allowance from age 2 and mobility allowance from age 5. In 1972, following the thalidomide tragedy, a "Family Fund" was established with Government money to give one-off grants to families with severely disabled children who could not get help from any other source.

6.8.5

Another oddity which owes more to politics than rational administration is the Vaccine Damage Payments Act 1979. It was born out of widespread concern that the pertussis vaccine was unacceptably dangerous and strong lobbying of Parliament by parents who believed their children's convulsions and subsequent disability was attributable to it. The Act (passed not fortuitously just before a general election) awarded L10,000 to anyone whose vaccination could be demonstrated on the balance of probabilities to have caused severe disability. Naturally the Government has contested cases vigorously and of 3238 claims only 400 have been awarded immediately and 432 after appeal. In view of the dashed hopes of unsuccessful families it must be doubtful whether the Act has increased the sum of human happiness; it also demonstrates that simply removing the need to prove **negligence** is an irrelevance when the actual cause of disability is in doubt.

6.8.6

As mentioned in para 4.8.6, the UK is reluctant to spend resources on the vocational rehabilitation of older disabled workers who are unlikely to find employment; but unlike most countries it provides no easier access for them to the disability pension program. Although age is one of the factors taken into account in assessing entitlement to Invalidity Benefit, currently many thousands of unemployed disabled people are nearing retirement age with no entitlement to any insurance benefit, or any benefit at all (for the reasons given in para 3.8.8).

6.9.1

This section has examined the information provided on benefits for disabled children and for people disabled before or soon after starting work and on the policies in relation to those becoming disabled near the normal retirement age.

6.9.2

Some form of extra cash benefit in respect of disabled children is mentioned in four countries, Austria, Israel, Sweden and the UK; but as no specific information was requested it may well be that there is assistance in other countries' programs too. How benefits for disabled children should be structured is not immediately obvious. Extending the criteria for adult benefits may not necessarily be appropriate; the extra expenses may be very different and the major financial effect on the family may in fact be the loss of one parent's income. It would be valuable to collate national research on the issue and possibly embark on a separate study.

6.9.3

The treatment of the disabled child once he or she reaches working age was central to the study and full information was received from each country. In five countries some non-contributory benefit is payable. In Israel there is total equality between insured and non-insured with a flat rate scheme; in Sweden and The Netherlands people disabled from birth receive the basic disability pension while people who have worked may receive an earnings related supplement. In Finland and the UK they receive a fairly low basic pension and will probably also receive means-tested supplements.

6.9.4

Of the other three countries only Austria makes it easier for young workers to become insured by relaxing the contribution conditions; they are also very easy to satisfy in Finland and the UK; in Canada and the FRG, however, five years contributions are necessary.

6.9.5

With advances in medicine, people disabled from birth who might have died in childhood thirty years ago may now expect to live though adulthood and perhaps have a normal life span. If it is accepted that they have a right as citizens to full participation in the community, the provision of a basic income must surely be essential. Three of the four countries have accepted this fully and two in part; so the direction in which policy is moving is clear. Responsibility must lie with national government; but the Netherlands has shown that a coherent system can be devised which continues to administer benefits though independent institutes. The cost of paying an adequate benefit to this group on its own is comparatively small especially as there are bound to be some savings to other programs. At present only The Netherlands and the UK give non-insured people disabled from childhood explicit advantage over non-insured people disabled later in life; although this is discriminatory, it could be considered as a first step to the more egalitarian programs in Sweden and Israel. Nevertheless, partial solutions always create worse anomalies and it would be unjust not to award the same benefit to young people who became disabled in the period of preparing for employment, i.e., during education or training, and while at work before they have qualified for the full contributory scheme.

6.9.6

Most countries concentrate vocational rehabilitation on younger workers. At times it is difficult to determine whether rehabilitation is seen as a reward or a punishment! In Finland it is described as an additional benefit, while in Sweden the phrase used is that elderly persons **"are not required to submit"** to rehabilitation measures.

6.9.7

This ambivalence no doubt also reflects the ambivalence of the general population about work and retirement. A study quoted in the UK monograph asked the following question of people who had been off work for varying periods:

> **"Assuming you were not ill and had enough money to live on, would you prefer to be at home or at work? Of those who had been ill for one month 20%, preferred to be at home whereas in the 12 month group this dropped to 10%"**

The issue cannot be separated from general social attitudes and policies concerning retirement; and it may well be that the cycle of education, training, work and retirement, which has, after all, only been obligatory for less than a century, will be reformed. For example, it may become customary for people to return to education on reaching "retirement" age; people may in fact train, work and retire several times in their lives. Many people who become "incapable of work" may also be perfectly capable of branching out in a new direction.

6.9.8

Of course the overriding factor in many countries is keeping the expenses of the benefit program within bounds. Comprehensive data on unemployment benefits were not always provided, but it can safely be said that everywhere a claimant will receive more money if he can be squeezed into the disability pension program. The upgrading of people with a partial incapacity has already been discussed, and many countries make it slightly easier for older people to satisfy the vocational criteria, usually by restricting the test to ability to perform their last job. The country which has wrestled most carefully with the problem is Sweden, and the changes in policy there have been quoted at length.

6.9.9

There would appear to be two principles which should guide national policies. First, the right to rehabilitation should not be restricted by age; to discard someone from the mainstream of the community life at the age of 45 when he or she may easily have another 45 years to live is unacceptable. The corollary is that any collusion by employers, trades unions or benefit administrations to "retire" people early on disability pensions against their will should be firmly resisted.

6.9.10

On the other hand, a modern society, where the average individual has little economic power and influence, surely has a duty to ensure that all citizens who are unable to obtain employment receive at the very least an income which not only raises them above poverty but also allows them to participate in the life of the community. One rationale for benefit payment suggested in the UK monograph is that benefit would only be denied to people

> **"if they actually refuse specific employment of which they are capable without good cause."**

In essence this is only a generalisation of themes current in a number of countries in relation to disability pensions. While it may always be necessary to distinguish voluntary and involuntary unemployment, so many countries have recognised that medical factors play only a minor part under modern conditions, and that a more general, more flexible, approach is essential if the divisions in our societies between people with and without employment are not to become so wide that they are both morally unacceptable and politically dangerous.

7. THE EFFECT OF NATIONAL ATTEMPTS TO REDUCE EXPENDITURE AND THE INFLUENCE AND ASPIRATIONS OF DISABLED PEOPLE AND THEIR ORGANISATIONS.

7.1.1

No evidence is given of any major changes in Austria which have reduced benefits or services for people with disabilities; although mention is made of intentions to modify aspects of pension insurance, the effect of the amendments is not stated. (It would have been particularly interesting to know whether any reductions in service had fallen first on disabled people without legal rights, i.e. those outside the insurance schemes.)

7.2.1

There do not appear to have yet been any reductions in benefits under the Canada or Quebec Pension plans. Fear is expressed, however,

> **"because of the ageing population and the corresponding drain on the Pension Fund. If current trends continue, the fund will be out of money by the year 2004; a solution could be a phased increase in CPP contributions and an increased maximum contributory earnings level, which now limits the contributions of people with high incomes."**

Such projections are notoriously unreliable, but this demonstrates that typing disability pensions to retirement pensions can be double edged. If the disability lobby is comparatively weak in times of prosperity, advantages can be gained on the coat tails of a national consensus to improve the status of senior citizens. The reverse of the coin is that in times of recession the very size of the retirement pension program may prove a millstone. Elsewhere has been noted the importance of deciding whether disabled people unable to work should be treated on a par with their contemporaries in work or with retirement pensioners. One additional factor, which may vary from country to country, is the extent to which retirement pensioners in general have private pensions which people with modest work records due to disability are unable to accrue.

7.2.2

No attempt has been made in Canada to date to extend eligibility either through pensions for partial disability or by including the non-insured, but this is an issue under discussion.

> **"The federal plan does not provide for non-earners or partially disabled people. They therefore have to rely on the safety net, the many provincial and municipal programs that, alone or in combination, provide a basic income for disabled people. The CPP may, in fact, exclude too many people, therefore causing an excessive reliance on the safety net."**

7.2.3.

Three goals are stated:

> **"(1) to ensure that disabled individuals who cannot work will receive benefits at a level compatible with the cost of living, through cash transfer payments and income-in-kind;**
> **(2) to ensure proper rehabilitation assessment (including medical and vocational);**
> **(3) to ensure that vocational rehabilitation is the first option, allowing those who want to and who can return to work the best chance to maximise their earning potential."**

7.3.1.

In the Federal Republic social insurance appears to have afforded good protection to people with disabilities within its scope against financial hardship arising from mass unemployment. It is also possibly true that the general pressures on budgets were later in arriving and measures to reduce costs which have already been taken in other countries are only now coming under consideration. Mention has already been made of the fears that the pension funds will not be able to cope with a society in which the percentage of the population in employment continues to shrink. The automatic right of people classified as 50% disabled to other benefits is also being questionned as was noted in para 5.3.2.

7.3.2.

Both the monograph and questionnaire have, however, been completed purely from the point of view of the administrative bodies and it is impossible to glean any real idea of the aspirations of people with disabilities and their views on how the current system really serves their needs. From the point of view of Rehabilitation International's member organisation, the Federal Rehabilitation Council, the priorities are as follows:

> **"The complexity of rehabilitation, and the financial limits posed, force us to lay down standards which aim to bring the right patient to the right rehabilitation centre at the right time, where he will learn the right rehabilitation behaviour. (The Council) has sent all practising doctors a 240 page in-depth book as a pointer.**
>
> **"We should take the lessons learned in rehabilitation and apply them, to achieve better prevention...**
>
> **"The rehabilitation of rehabilitation has begun. We know that this will be a continuing task now and in the future.**

The response to current conditions appears to be to try to make an already efficient system even more efficient. The law of diminishing returns is, however, likely to render this approach increasingly ineffective. If it is accepted that the workforce will continue to shrink, a broader goal for rehabilitation is necessary. The wording of the 1974 Act which refers to integrating the disabled person into society should perhaps be incorporated within social insurance. It is also difficult to believe that people with disabilities will continue to be content with what appears to be a two-tier system for the insured and the non-insured in regard to rehabilitation as well as to pensions.

7.4.1.

No evidence is given that people with disabilities in Finland have suffered at all from the cold winds of recession affecting other countries. All the changes mentioned in the last few years appear to have been designed to ease access to benefits. Despite criticisms of the apparent complexity and high administrative costs of the plethora of schemes and insurance bodies, private or semi-private insurance does seem to be more resilient than state schemes.

7.4.2.

As noted earlier the voice of people with disabilities is absent from the data and it is therefore only possible to hypothesise as to whether the programs are meeting their aspirations. One possible defect is that all appear to be based on an original condition causing incapacity for work. It is not clear what level of assistance is given to severely disabled people in full-time employment outside the accident and motor disability pension schemes.

7.5.1

In Israel it may seem surprising that so many improvements to disability benefits have been possible over the last ten years; certainly there is no evidence that people with disabilities have suffered any retrenchments.

7.5.2

The voice of disabled people themselves is beginning to be heard, although as yet their influence on the programs appears slight.

> **"With the recent recognition of the rights of disabled persons as a consumer group, it may be appropriate to consider the setting up of a joint committee consisting of representatives of disabled persons associations and of the disability benefit program administration to consider ways and means of simplifying procedures and to improve channels of communication and understanding."**

And the conclusion of the monograph:

> **"Finally, and what is probably most important is the need to find new ways and means to involve the disabled person as a consumer, together with the voluntary associations that represent disabled persons in the process of assessment, evaluation, provision of benefits, rehabilitation and entry or return into the world of work."**

7.6.1

It is probably fair to say that Sweden is generally regarded as having been in the vanguard of giving people with disabilities the opportunities and facilities they need to enjoy full and equal rights as citizens. Of equal importance, organisations of disabled people apparently enjoy more political power in Sweden than anywhere else in the world. Democratic involvement in the actual functioning of the social security system also seems more prevalent than anywhere else, and this should prove a substantial protection against retrenchment.

7.6.2

Certainly the grip of the medical profession on disability pensions is far looser in Sweden. In formulating the proposals for replacing the pension delegations (see para 3.6.4) the Minister of Health and Social Affairs agreed that

> **"the social insurance boards should comprise elective representatives with experience and knowledge of different fields. No professional category is to be given priority solely by virtue of its professional qualifications. Physicians, therefore, should not be appointed to serve on these boards solely in their professional capacity."**

It would not seem therefore that the outcome of the pensions review mentioned in section 6 is likely to be a reversion to stricter medical criteria.

7.7.1

As long ago as 1976 a senior Dutch civil servant entitled a paper about the Act which introduced the GDBA benefits in that year "Social Paradise Almost Lost." He was under few illusions that this marked the last advance for people with disabilities before a general retreat. The retreat was delayed a few years, but the new dawn which was encouraging disabled people in The Netherlands as elsewhere to take up their rightful place in society proved to be short-lived. The monograph describes painfully

> **"developments in The Netherlands which threaten to cast the handicapped back into a position of greater dependency."**

The new philosophy appeared to have been abandoned.

"The evolution from care for the poor to a policy of emancipation appears to have been abruptly terminated."

As we saw in section two, The Netherlands had taken up the motto of the International Year of Disabled People, "Full Paricipation and Equality," well before 1981.

"Yet in the 1980s, it appears that an about-face has been made. Needs have priority over desires, requirements are no longer aimed at improvement but at protection. The policy's driving wedge has shifted from personal fulfilment to the prevention of poverty and critical situations. The protection is limited and extends no further than the financing of basic requirements.

7.7.2

The reason for the change was the political and economic reaction to the high general levels of unemployment.

"Due to the vast unemployment and the large number of disability claimants, groups other than those noted as underprivileged in the 1970s are feeling the pinch. As more attention is paid to broader groups, the urgent situation of specific groups such as the handicapped and disabled is pushed further toward the background.... The focus on the free dynamics of power in society has contributed, most likely in an almost unobserved and unintentional way, to the fact that the handicapped and disabled are being forced to bear disproportionately large burdens as a result of the government's policy."

7.7.3

In a sense it matters little if the policy of emancipation was reversed deliberately or not, since indifference to the effects on people with disabilities of the new programs indicates that the philosophy behind the policy was not understood by the politicians. Indeed very few people without a disability really seem to understand the issues:

"Handicapped persons are saddled with a double dependency, owing to the often high additional costs related to their particular handicap.... The government has too little understanding of this wholesale dependency on the public sector on the part of the handicapped and disabled."

7.7.4

If cuts in public expenditure are necessary, it would seem sensible to choose those which do not generate equal or greater expenditure elsewhere or vitiate the purpose of other items of expenditure. For example small cuts in budgets for domiciliary services can lead to much greater increases in the need for residential care. The main complaint in The Netherlands is that:

"These public spending cuts are implemented in a very uncoordinated manner and are accompanied by all the resulting negative effects on the individual disabled person."

7.7.5

Most anger seems to be levelled at the cuts in services rather than the cuts in benefits (for example the reduction in the maximum rate of DIA from 80% to 70%).

> **"In the past, efforts to improve the position of society's weakest members were based on the general right of access to facilities and services for all those having need of them. Yet as these facilities and services are dismantled, chaos occurs. The attempt is currently being made to rectify the blatant cases of inequality produced by the spending cuts. This is the logic of shattering the teacup against the wall before carefully glueing it back together again."**

7.7.6

At the time of writing further major revisions of the labor disability Acts were under discussion. The main target for savings were those people receiving maximum benefit under the "double evaluation" procedures when their theoretical labor disability is less than 80%, on the grounds that their disability is the cause of their failure to find work.

> **"The government feels the current procedures under the disability programs cause inequality between the unemployed and the disabled, to the extent that the latter still possess residual working capacity."**

The spokesmen for people with disabilities take the opposite view and argue that

> **"the disabled, with their residual capacity, always assume a less favourable position on the job market than do those unemployed persons without functional limitations."**

This is undoubtedly true; but it does not explain why two people without work should receive different amounts from society to meet their basic needs. It turns social security rather into a game of poker: the person at the table with the second best hand loses the most money. This is of course not to say that the *additional* needs of people with disabilities should not be met by *additional* payments—whether they are in employment or not.

7.7.7

Three principles are enunciated for Government to follow if disabled people are to maintain equality and continue participation in society.

> **"• the handicapped do not sacrifice more of their incomes than allowed for in the wage agreements of comparable groups in paid employment; • the handicapped and disabled are not asked to shoulder further costs resulting from their handicap. This can only be realised if the current spending cuts applied to the facilities and services are withdrawn.**
>
> **• ...extra costs resulting from the handicap should not place disproportionately great pressure on the private budgets of the individual. This should serve to prevent individuals from being profoundly and negatively affected by the spending cuts due to their great dependence on the services."**

7.8.1

Real improvements in the position of people with disabilities in the UK only really began in the late 1960s. These coincided not only with a period of economic growth, but also with the emergence of independent organisations of disabled people. The introduction of Attendance Allowance and the passing of the Chronically Sick and Disabled Persons Act 1970 were followed in 1975/6 by the non-contributory invalidity pension, invalid care allowance and the mobility allowance. The watershed, however, was really the 1973 oil crisis and, since then, extracting additional public expenditure from successive governments has been a very difficult task.

7.8.2

Paradoxically, social security and public expenditure generally on disabled people has increased significantly because of the aging population, the steep rise in unemployment and the disproportionate increase in the costs of medical care. A rough estimate is that expenditure on health and social services has to increase by 2% per annum simply to maintain existing standards of care. In this context it is easy to see how the growing ambitions and aspirations of people with disabilities—in particular during the International Year of Disabled People—have had to endure continuing frustration.

7.8.3

The social security budget has been trimmed at the edges year by year despite its overall increase and the cuts for people on Invalidity Benefit have been described in para 2.8.6. One of the main campaigns of the Government has been to reduce local authority expenditure by reducing the general level of grants, by specific grant reductions for high spending authorities and by limiting the level of local rates (property taxes) that can be set. This has inevitably affected the ability of authorities to meet their legal obligations under the Chronically Sick and Disabled Persons Act 1970.

7.8.4

The major specific demand of organisations of disabled people has been for general anti-discrimination legislation. Although the main inspiration has been the USA Rehabilitation Act 1973, the structure of that Act would be less appropriate in the UK and proposed legislation has been modelled on UK Acts relating to sex and race discrimination, which have themselves been successfully extended to disability in a number of Australian States. Such legislation was the key recommendation of a Government funded committee which reported in 1982, but two private members Bills were defeated in the following sessions in the face of explicit government opposition.

7.8.5

It would, however, be a mistake to describe the last ten years in the UK as a period of unalloyed gloom since there have been several major improvements, especially in transport and building laws, which will have a direct effect on the ability of disabled people to participate in everyday life. The right of disabled people to be consulted about decisions that affect them was also unanimously accepted on all sides in the Disabled Persons (Services, Consultation and Representation) Act 1986, even if the resources to implement the Act have not yet been allocated.

7.9.0

In summary, the achievements of the last twenty years in terms of self-confidence, political awareness and group identity are ineradicable. People with disabilities have proved reasonably successful compared with other groups in protecting their position and their acceptance as citizens entitled to full equality is now almost universal; making people understand what is necessary to achieve this and persuading public bodies to provide the necessary resources is a harder problem.

7.9.1

Although the topics chosen in this section were believed to be of general interest, in most countries there is only incidental reference in the questionnaire and monograph either to cuts in benefits and services or to the role of organisations of disabled people; comparisons therefore must be more than usually hesitant. Also the fact that half the questionnaires were completed by people connected with the administration of the benefit programs and half by people more aligned with the claimants inevitably means that some submissions are more self-critical than others.

7.9.2

It is also particularly important in this context to remember that in almost every country "people with disabilities" and the recipients of the SSDI equivalent program are by no means equivalent groups—indeed they may not even overlap very much. It is arguable that the main beneficiaries under disability pension schemes which act as early retirement programs may have comparatively modest disabilities in relation to everyday living; and that the most severe disabilities will be found among (a) people who have never been able to work and (b) very elderly people. The habit of using the words "disabled" and "disability" both in the WHO sense to describe functional limitations and in the SSDI program sense of incapacity for work can lead to considerable confusion when the context is not crystal clear.

7.9.3

For example, it has been suggested from the available evidence that insurance programs which confer legal rights are less likely to be curtailed than general, discretionary, social assistance programs. If the hypothesis in the previous paragraph is also correct, then within a country with a clear dichotomy between insurance schemes and social assistance, it would be probable that any cuts would fall on people with the more severe disabilities; and a description of the circumstances of insurance beneficiaries would give a very false picture of the position of disabled people generally within the country.

7.9.4

The only substantial account of the reaction of organisations of people with disabilities in face of recent cutbacks comes from The Netherlands; and there is little which needs to be added by way of commentary. One cautionary note from other countries too is that advances in the past may have been attributable overmuch to old fashioned and inappropriate concepts of charity and to vague feelings that disabled people were a "deserving" group. Unless the benefits and facilities people with disabilities need for full and equal participation in society are seen as a basic civil right, they will never be securely established. Also, as The Netherlands indicates, unless disabled people themselves are involved in decision making, cuts made by able-bodied people ignorant of the needs and issues are likely to lead to more expenditure, not less. Perhaps the most important civil right is the right to participate in the decisions which affect one's life; all future decisions on changes in programs for benefits or services must be made in conjunction with the representatives of disabled people themselves.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1

A final quotation—from an author who did not contribute to the RI Study but who should surely have been asked to do so if he had been alive today since his ability to analyse the impenetrable may never be matched:

> **"All happy families resemble each other, each unhappy family is unhappy in its own way."**

8.2

Tolstoy's view of families is an appropriate comment on the main programs under discussion. All countries have achieved a system which serves without much problem the people whom it was originally intended to serve: people who had worked and paid insurance contributions and who became beyond question incapable of work. For this substantial central core there may not be much to choose between the different systems—all are more or less satisfactory both from the point of view of claimants and administrators.

8.3

It is when countries began to realise that there were large numbers of people whose circumstances were very similar but whose needs were not met by the basic system that serious problems began to arise and different countries bent and adapted their system in a variety of ways in order to meet the needs of this group or that group. In only a few cases, however, does there appear to have been an attempt to return to first principles, to look at the entire population potentially in need of benefit and to create a clear and consistent program in tune with modern needs and values.

8.4

The previous sections indicate how different countries have given priority to different groups: some are concerned with helping the young, some put more emphasis on older workers. A multitude of different schemes are devised either to give benefit or deny benefit to married women. Yet to stretch the quotation from Tolstoy a little further, it does seem possible to discern a similarity between those countries which have adopted the happiest solutions; or to put it the other way round, where there seems to be the greatest agreement on priorities the results appear most happy. Several recommendations have been made during discussion in each section. The following should not therefore be regarded as exclusive.

8.5

Recommendation 1 is that all countries who have not done so incorporate in their main programs a minimum benefit which is adequate to meet the basic financial needs of people who have never had the opportunity to make the contributions necessary for the main disability pension program. The cost is unlikely to be very great in view of likely savings in other programs and the effect would be a considerable enhancement of the status of people disabled from birth or childhood.

8.6

Recommendation 2 is that a specific study is undertaken of the reasons behind the amazing variety of provisions relating to women who might, or do, become uninsured because of family responsibilities.

8.7

Recommendation 3 is that RI asks member organisations to collate information available nationally on the financial needs of families with disabled children.

8.8

Recommendation 4 is that all countries who do not do so examine closely the possibility either of combining the administration of benefit assessment, vocational rehabilitation and of job placement, or at least of appointing identifiable officials whose responsibility it is to guide claimants through from beginning to end; they might be called rehabilitation counsellors.

8.9

Recommendation 5 is that a study is undertaken to explore the grey area between disability/incapacity and unemployment. In theory it would be illuminating for a number of people to be submitted to adjudication in a variety of countries; but this is obviously impossible. It might be possible, however, for countries to submit sufficiently detailed case studies for a paper adjudication to be done. Although the general approach is discernible from this study it is not until the effects of different policies are seen on real people that they can properly be evaluated.

APPENDIX A
THE DEFINITION OF DISABILITY

"When I use a word," Humpty Dumpty said in rather a scornful tone, "it means just what I choose it to mean,—neither more nor less." ***Through the Looking Glass*****, Lewis Carroll.**

Introduction

Following is a discussion by Peter Mitchell of three papers on disability definitions and their applications in Social Security and other benefit programs. The papers, by Prof. David Symington of Queens University, Canada, Prof. Harlan Hahn, University of Southern California, USA and Prof. Deborah Stone of Brandeis University, USA, were presented to the International Research Conference on Social Security Disability Programs, held by Rehabilitation International and the U.S. Social Security Administration, April 1986 in Baltimore, Maryland, USA. The papers are available from Rehabilitation International.

Major reference is also made in the discussion to the World Health Organization's manual, "International Classification of Impairments, Disabilities and Handicaps, published in 1980 (ISBN 92 4 1541261), available from WHO Publications, Geneva 1211 Switzerland.

The need to escape words or phrases which have become pejorative has been a continuing struggle for people with impairments, especially for those with mental impairments. The word "cripple" was superseded by "the disabled" which has now largely given way to "disabled people" or "people with disabilities". While the values attached to words are undeniably important, the prime function of language must be communication. Periphrases which leave the meaning opaque may have short term political advantages but the confusion the necessarily engender makes them a poor basis for social policy.

The logical starting point for an investigation of the meaning of "disability" is the World Health Organisation's International Classification of Impairments, Disabilities and Handicaps (ICIDH). The defintiions were explained by David Symington.

> **"*impairment* is defined in the context of health experience as 'any *loss* or *abnormality* of psychological, physiological or anatomical structure or function' Impiarment represents deviation from some norm in the individual's biomedical status. It is characterised by losses that may be temporary an anomaly, defect or loss in a limb, organ, tissue or other structure of the body. It also includes a defect in a functional system or mechanism of the body, including the systems of mental function."**

It is important always to remember the words used in all the ICIDH definitions—but often omitted in quotation—" in the context of health experience." Even in the classification of impairments there are items which may be regarded as social judgements rather than biological facts and it is not surprising that Disabled Persons International is critical of the document, as indeed are some health professionals. David Symington stresses that impairment "does not necessarily indicate that the individual should be regarded as sick." This, however, is not enough. Even in common parlance no one would describe someone who had lost a limb in an accident as sick. The whole concept of impairment presupposes a consensus on what is a whole person. It is essential therefore to regard a classification merely as a working tool, not as some divinely ordained judgement.

That said, the definition of impairment causes little practical difficulty. It is with the definition of disability that differences begin to arise. David Symington continues:

> **"*disability* is defined as —'any restriction or lack of ability to perform an *activity* in a manner or within the range which is considered normal.' Disability is concerend with compound or integrated activities expected of the person or of the body, as a whole, such as tasks, skills and behaviours.**
>
> **Disability repesents a departure from the norm in terms of performance of the individual, as opposed to that of the organ or mechanism."**

It is hardly surprising that Harlan Hahn—and DPI generally—should react to this definition and maintain that "the departure from the norm" is caused not by an individual's impairment, but by his environment i.e. that it is society that disables people not impairments. Before looking at his criticisms in detail, however, it is convenient to consider the third component of ICIDH as explained by David Symington:

> **"*Handicap* is defined as—'a *disadvantage* for a given individual, resulting from an impairment or a disability that limits or prevents the fulfilment of a role that is normal for that individual (depending on age, sex, social & cultural factors).' Handicap is thus a social phenomenon repersenting the social and environmental consequences for the individual stemming from the presence of impairments or disabilities.**
>
> **"The state of being handicapped is relative to other people, hence the importance of existing societal values, which in turn are influenced by the institutional arrangements of society."**

The example is given of an adult with diabetes who has an impairment but is not disabled unless his lifestyle is restricted other than by diet or drugs. Even if he is disabled because of the need to restrict heavy exercise, he is not vocationally handicapped provided that he is employed in sedentary work. The example is not, however, as clear cut as it may seem at first sight. The individual may well regard the regime of diet and drugs as a restriction on a normal activity (i.e. the consumption of food and alcohol) such as to bring him within the definition of disability. He may or may not feel the restrictions amount to a social handicap; and even if he has a sedentary job, his lack of choice were he to lose his employment could be said to amount to a vocational handicap. This is not intended as a criticism of the ICIDH distinctions, merely a reminder that values are incorporated at all stages of the process.

Harlan Hahn begins his paper in forthright style:

> **"In recent years, the definition of disability has shifted from a *medical* approach, which stressed functional impairments, and from an *economic***

> **orientation, which emphasised vocational limitations, to a *socio-political* perspective, which regards disability as a product of the interaction between the individual and the environment. From the latter vantage point, the principal problems confronting persons with disabilities can be attributed to a disabling environment rather than to individual defects or deficiencies."**

It would, however, be slightly more accurate to say that the *use* of the word had changed rather than its *definition*. To speak of a change in definition implies that there is an object or a concept which is generally recognised or understood but which has to be refined in the light of experience. For example the definition of "swan" probably included the adjective "white" until the discovery of black swans in Australia. What Harlan Hahn is describing is the change in self image of people labelled "disabled" who, feeling stuck with the word, are determined to change its meaning.

It is hardly surprising, therefore, that he should complain that

> **"disability in the United States and elsewhere is infused with inconsistent and contradictory definitions and concepts."**

This complaint would seem to be based on the premise that "disability" is a Platonic Form (ειδος) rather than just a poor overworked word. What he calls the "minority group paradigm" challenges

> **"the traditional premises in policy that have tended to equate disability with unemployability, or an inability to engage in 'substantial gainful activity. On the contrary the failure to provide an appropriate environment for disabled persons...is regarded as an issue of discrimination."**

Confused language may well lead to confused social policy. If the generic phrase used to identify people with impairments is also used for people adjudged incapable of work then the discrimination identified by Harlan Hahn may well be a consequence it is difficult to avoid. The answer must surely be to allocate separate words once the concepts have been disentangled rather than to seek a "true" meaning of a particular word. In her paper, *Deborah Stone* uses the word "disability" as a label which identifies people who deserve to have resources allocated to them which they cannot obtain through their own labours.

> **"Disability is part of a larger problem of distributive justice. All societies have two distributive systems, one based on work and the other on need. Both systems are necessary: distribution according to work in order to ensure economic production and stimulate productivity, and distribution according to need in order to preserve community, express compassion, and ensure human survival. But these systems coexist in an uneasy tension. The two principles tend to undermine each other. The policy problem for any society is to decide when the normal work-based rules of distribution should be suspended and some form of social aid should take over."**

It is perfectly possible to accept both Harlan Hahn's view of discrimination and Deborah Stone's thesis concerning the distribution of resources; what is not acceptable is the continued use of the word "disability" in two completely different senses.

Deborah Stone devotes the remainder of her paper to describing the different criteria for disability pensions in the United States, the Federal Republic of Germany and The Netherlands. The two latter are described in detail elsewhere. The particular aspects she highlights are: the US requirement to take a job anywhere in the nation, which she ascribes to the "frontier spirit"; the German stipulation that someone cannot be required to take employment which would "entail a significant decline in social status" which she attributes to recognition that "jobs provide not only income but a social identity"; and the Dutch rules which test people's abilities against only locally available employment "which gives explicit recognition to the importance of community." These aspects are not, of course, unique to these countries, as has been seen.

Her conclusion is that

> **"societies have a great deal of *choice* about how they define disability, and that they will implement different types of justice by choosing one definition rather than another. In the flurry of concern over expansion of disability programs since the 1970s, politicians and disability specialists have tended to look for single, technical, hard and fast, 'correct' definitions...On the contrary disability definition is not a technical matter but a matter for political decision in specific societies."**

After discussing the ICIDH definitions in the abstract, David Symington considers the correct ICIDH nomenclature for various existing benefits. The pensions paid by the Canada Workers' Compensation Board should be described as *impairment pensions* since they are based upon assessment of impairment without regard to the degree of disability or vocational handicap.

> **"This system makes medical evaluation relatively easy, but creates much hardship and bitterness in those vocationally handicapped workers, who are unemployable because of a relatively minor impairment."**

While simplicity may originally have been a good reason for this method of compensation and there is some instinctive feeling that someone who has lost something should receive something in return, assessment of impairment in percentage terms must be wholly arbitrary unless it is related to economic disadvantage, either loss of income or extra expenses. While no country has extended assessments purely on the basis of impairment outside schemes for special groups, it is surprising how many still put so much effort into assessments of impairment before making the final decision on socio-economic grounds.

As an example of a true *disability pension*, he cites the mobility allowance in the United Kingdom which is paid to people unable or virtually unable to walk—which fits the ICIDH definition exactly. It is pertinent to note that the purpose of the allowance is to enable people with this disability to reduce the mobility handicaps they would otherwise encounter. It would be interesting to know how Harlan Hahn would describe this. While much of the mobility handicap clearly results from an environment which discriminates against people who cannot walk, it is difficult to imagine any environment where they would not be at some disadvantage. (Although a world designed solely for wheelchairs has been conceived by the South African born English pyschologist Vic Finkelstein, this is more of a political than an architectural statement.)

David Symington suggests that another example of a disability pension is the attendant care supplement paid by the Canada Worker's Compensation Scheme; as has been seen, a similar benefit is paid in many countries. He proposes that a benefit should be called a disability pension if it is determined solely on the basis of disability irrespective of social, vocational or economic status; but he implies that it would be better called a handicap pension if it was specifically related to particular external circumstances. This distinction is not wholly clear. Would a mobility allowance paid solely to people who needed it to get to work become a handicap pension? Perhaps the better distinction is whether the pension is designed to *overcome* the handicap or to *compensate* for it. This interpretation is supported by his suggestion that rehabilitation and special equipment can be regarded as non-monetary disability benefits, designed to reduce or overcome vocational handicap in exactly the same way as mobility allowance may reduce mobility handicap.

As an example of a *handicap pension* he cites the Canadian Disability Pension Plan which is practically identical to SSDI and broadly similar to the benefits in the other seven countries which were generically called disability pensions in Chapter 2, solely on the basis that that was the most common name employed.

> **"As defined by WHO, a handicap pension would, in my view, be provided on the basis of an existing social disadvantage resulting from an impairment or disability."**

In other words, the pension is paid on account of vocational handicap arising from impairment or disability. As described earlier, a dual approach is employed in Canada.

> **"Eligibility here hinges on two conditions. First, the presence of a severe and prolonged mental or physical disability. This calls for a medical determination, which does not pose a great deal of difficulty for a physician in most circumstances. The second condition, namely certification of incapacity to pursue any substantially gainful occupation, is commonly required from a physician and this, in my opinion, is inappropriate and a source of a great deal of difficulty."**

How each country tackles this difficulty has already been exhaustively described. In the context of definitions, or the use of words, there are two points of interest. First, the initial hurdle, present to a certain extent everywhere, is variously described as impairment or disability. Not much attention has been paid to the distinction since the translations may not have been too concerned with this point and in 99% of instances the vocational handicap will follow a disability which arises from an impairment. In some cases, however, this will not be so; for example, someone with severe facial disfigurement may suffer widespread discrimination from employers and fellow workers and be vocationally handicapped even though perfectly capable of work.

Second, "handicap" is, of course, a word which was used for hundreds of years before being associated specifically with impairment or disability. To call SSDI a "vocational handicap pension" would be logical; but it would draw attention to two facts: first, that vocational handicap is more complex than the simplistic distinction between being capable or incapable or work; and second that other groups have similar or greater handicaps based almost totally on discrimination; for example (according to country): women or minority ethnic groups. The logic of Harlan Hahn's approach—that disability is caused by discrimination—might lead to a difficulty in selecting vocational handicap caused by disability for special assistance. It may be objected to that the first use of the word "disability" in this sentence is in the sense of ICIDH "handicap" and second is equivalent to ICIDH "impairment". Yet if he believes that vocational handicap is caused by discrimination and not by impairment it is even harder to justify a handicap pension based on impairment criteria.

The conclusion may therefore be that within the SSDI programme in particular (in view of the absence of national unemployment schemes) the confusion over the meaning of "disability" is necessary in order to restrict handicap pensions to people with impairments. There may well be a national consensus that people with impairments deserve help and a sustainable belief that "incapacity for work" is a precise and provable condition. Conversely it may be politically advantageous for the public to believe that "disability pensions" have some logical connection to "people with disabilities", although the analysis shows that the two have little in common.

From the linguistic point of view, however, the aim is to develop a common language which will convey the meanings and concepts of all parties to the discussion whether their approach is medical, economic, political or whatever. For all its inadequacies, ICIDH does seem to provide a basis for this. The apparent conflation by Harlan Hahn of the ICIDH concepts of impairment and disability and his use of disability more or less as equivalent to ICIDH handicap do seem to lose the advantage of some useful distinctions. For example, the inability to walk may arise from various impairments; but it is not a condition which can be cured by anti-discrimination legislation or the provision of benefits. Equally the inability to go shopping may arise from an inability to walk; but it may equally arise from blindness, intellectual impairment or agoraphobia. The same handicap may be overcome in a different way: a barrier-free route, a guide dog, a companion or counselling; or in the same way by becoming a passenger in a car. Indeed the very phrase "people with disabilities" would need to be changed to "people with impairments" unless it is genuinely intended that with an end to discrimination the category would cease to exist.

Equally, while the phrase "a disabling environment" is a striking one, not much is lost by saying that "the environment handicaps people with disabilities" rather than "the environment disables people with impairments''. What is a genuine loss is the inability to use the phrase ''a disabling environment'' for one which actually reduces functional ability without necessarily causing impairment. For example, people operating in extreme heat or cold or underwater may be *disabled* by the conditions; they would, however, only be *handicapped* compared to the native fauna since the notion of disadvantage is a relative one. Under more normal circumstances I would call a heavily smoke filled room a disabling environment if it reduced my working ability; it could also be described as handicapping me relative to seasoned smokers and as potentially causing me permanent impairment.

Deborah Stone uses the word ''disability'' for whatever complex criteria countries use in their SSDI equivalent programmes; this is really too heavy a burden for a simple word to bear. The differences she cites all relate to vocational criteria, or indeed to social criteria, not to the underlying impairments. While the Dutch approach quoted could in theory be linked to the greater need of people with impairments to remain near existing sources of support, it is not so obvious why, in Germany, they exclusively should not lose social status. In fact, as she suggests, these criteria have nothing to do with impairment itself, but with what different countries expect it is reasonable for people to do in order to avoid moving from what she calls the work-based to the need-based system.

Since this is a complex idea, it is unreasonable to attempt to encapsulate it in a single word. If David Symington's approach is followed the basis of the pension is vocational handicap, but the additional factor is that a means of overcoming the vocational handicap can be ignored if it would involve an increase in social handicap—whether or not this handicap can be directly traced back to disability.

In conclusion, therefore, David Symington's analysis and adaptation of the ICIDH to financial benefits does, to my mind, make it easier to understand the very different ideas and approaches of the other two authors. While the detail of ICIDH can obviously be improved, it would greatly enhance national, let alone international, understanding if its basic definitions were adopted and the appropriate terminology used in benefit programmes.

APPENDIX B
A SELECTED BIBLIOGRAPHY

Social Security Disability Benefit Programs and Rehabilitation

Following is an annotated list of books, reports, conference papers and articles from selected journals, on social security disability benefit programs and rehabilitation. The material was collected during the course of the RI project on social security disability benefit programs and covers, roughly a four year period, 1982-86. Several associated topics are included: analyses of disability and social policy, studies of socioeconomic data related to social security and vocational rehabilitation programs.

Books and Reports

Book Review

Public Policy Toward Disabled Workers: Cross-National Analyses of Economic Impacts by Robert H. Haveman, Victor Halberstadt, Richard V. Burkhauser. Cornell University Press, 1983.

Public attention was focused on disability policy in the United States briefly in 1983 and 1984 as the press and television featured horror stories of persons suffering, some to the point of taking their own lives, as they were cut off from Social Security disability benefits as a result of the reviews of persons on the rolls. Congressional amendments in 1984 changed but did not eliminate the reviews. Only in the spring of 1986 did the Social Security Administration cautiously return to the review of cases on the rolls as they were required to do by the 1984 reforms.

The initial reviews were dictated by legislation passed at the end of the Carter administration when the conventional wisdom was that many on the disability rolls should be up and about, working or seeking jobs. Congress took a long time to act once the tales of misery made their way to the front pages, and in that interim several governors simply refused to allow persons to be removed from the benefit rolls. As someone has remarked, it wasn't so much that Congress didn't have the answers, they were not very clear as to what the questions were.

Disability policy seldom commands the attention of the American public. Certainly, we have not looked upon disability policy in the same way we regard problems of the aging, or problems of poverty; nor does the issue usually lend itself to the kind of dramatic demonstration that has alerted the public to the problem of hunger. It is not that the problem is unimportant. Somewhere between 6 percent to 16 percent of the population classify themselves as disabled and it is likely that we allocate upwards of $122 billion a year in transfer payments, medical care payments and other services to disabled persons.

The problem is that the concept of disability is not easily understood. A disparate group of programs come under this rubric ranging from the venerable Progressive era program, workers' compensation, to the newest developmental disabilities legislation aimed at providing services to persons incapacitated at birth or early in life. Some programs are means tested, while eligibility for other programs depends upon a showing of fault, as in the tort cases, or, as in the Social Security program, an "inability to work" because of some physical or mental impairment. The difficulty is that some quadraplegics confined to a wheel chair hold down full-time jobs, whereas other persons are knocked out of the labor market by minor back ailments.

The authors of this volume attempt to put the problem of disability policy in perspective. About one-third of the pages are devoted to an examination of the American experience and a discussion of broad policy issues across seven countries. The balance of the volume consists of an examination of specific policies in the seven countries—West Germany, France, Israel, Italy, the Netherlands, Sweden and the United Kingdom. We have seen some of the descriptions of the American experience before in Burkhauser and Haveman's **Disability and Work** (Baltimore: The Johns Hopkins University Press, 1982) but here the policy is better articulated and an attempt is made to treat problems present in all the countries, such as the growth in the number of persons on the disability rolls.

A highly remarkable growth pattern during the period 1968 to 1978 is noted for most of the countries and analyzed in terms of the income support burden on the employed population. The record shows that the share of public expenditures accounted for by income transfers to the disabled more than doubled in this period in the Netherlands and Italy, and nearly doubled in Israel and Sweden. The data presented do not indicate any great increase in the numbers of persons with impairments, and the authors proceed to explain the changes in terms of a simple economic framework where the choices between disability status and work are seen as depending upon replacement rates and the value of leisure.

The illustrations of the economic model of disability are largely drawn from the U.S. experience, but brief sections are devoted to each of the other countries. The authors note, for example, that in the Netherlands, the determinants of growth are comparable to those in the other countries—the use of disability pensions to assist long-term unemployed older workers, the increases in coverage and benefit levels, and a relaxation of eligibility requirements. What they find surprising is the enormity of the growth given the extensiveness of the pre-1968 system. Two-thirds of the expenditure growth is accounted for by the growth in the total number of beneficiaries. "The experience suggests the absence of any "natural" limit to the potential population of disability beneficiaries." Certainly, it would seem so—and it may be true. However, the trend in recent years, certainly in the United States and less obviously in Sweden, the Netherlands and Israel, has been the slowing down of the rate of growth of disability expenditures and the number of disability beneficiaries, a phenomenon that is not easy to explain. In general, the cross-national analysis in Part I of the volume is quite good. We cannot fault the authors for not analyzing trends that became apparent only after the period with which they are concerned. Given the production time that elapses from the time the manuscript is completed to the time the book makes its appearance, we must expect the world to change, and changes have taken place in the disability field.

The problem of change is more apparent when it comes to the chapters on the individual countries. Jack Habib, in the chapter on Israel, distinguishes between the "newly disabled" and the "previously disabled". The distinction was appropriate at the time he wrote, but it has been invalidated by recent legislation. Valiant attempts are made in each of the chapters focusing on individual countries to concentrate on the economic issues, but inevitably, the descriptions of the programs get bogged down in institutional detail. The chapter on the Netherlands has the best balance between program description and economic analysis, written as it was by economists and a program administrator. The chapter on Sweden has an elaborate and detailed examination of some of the benefit calculations which seems pointless. One of the interesting elements of Sweden's experience with disability policy is the inability of the social insurance organization to command the attention of the labor market of health authorities when services are needed, yet this problem does not emerge from the close examination given to the separate programs.

The outstanding virtue of this volume is its focus on disability policy and a recognition that the corrective aspects such as rehabilitation and labor market policy must be related to the ameliorative or benefits side. Examination of the experience of the foreign countries for those who can find their way through the institutional thickets will demonstrate that, whatever the U.S. problem with disability policy, we are not alone. As a matter of fact, our problems seem to pale by comparison. One wonders whether anyone in this country would work if, say, the Netherlands system were in place here.

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Book and Report Descriptions

Analysis of Costs and Benefits of Rehabilitation, report prepared for the U.S. Department of Education by Office of Program, Bureau of Economic Research, Rutgers University, New Brunswick, NJ 08903, U.S.A. 1985, 474 pp., $15.00.

This report analyzes the economic theory underlying benefit cost analysis and presents new models. It uses data to produce a series of benefit cost ratios ranging from the simple to the complex using econometric and cook book types of modifications. Data available only at the state level are used to estimate new models and the first results of a mini-data link using state agency records and earnings data from the state unemployment insurance program are presented.

Challenges to Social Policy, edited by Richard Berthoud, Senior Research Fellow at the Policy Studies Institute, London, published 1985 by Gower Publishing Company Limited, Gower House, Croft Road, Aldershot, Hants GU11 3 HR, England and Gower Publishing Company, Old Post Road, Brookfield, VT 05036, U.S.A., 220 pp., $35.50 hard cover.

This book reviews the prospects for public expenditures and in particular for state welfare. In spite of the constraints the range of options open to government is shown to be wider than we are often led to believe. Constraints and options are examined for five specific policy areas: taxes and benefits for the working population and pensioners respectively; social services for families and for the elderly; and the promotion of health and health care.

Characteristics of Social Security Disability Insurance Beneficiaries, published November 1983 by the U.S. Department of Health and Human Services, Social Security Administration, Office of Policy, Office of Research, Statistics and International Policy, U.S. Government Printing Office, Washington, D.C. 20402, U.S.A., 187 pp.

This report presents statistical information on the kinds of people who receive Social Security disability insurance (SSDI) benefits. Statistics are presented on selected demographic, socioeconomic, and medical characteristics of persons who were allowed benefits as disabled workers during the period 1977-79, inclusive. Figures are shown for each year separately.

Disability and the Labor Market: Economic Problems, Policies and Programs, edited by Monroe Berkowitz and M. Anne Hill, published 1986 by Cornell University, ILR Press, New York State School of Industrial and Labor Relations, Ithaca, New York 14851-0952, U.S.A., 336 pp., $34.00 cloth.

Recent amendments to social security legislation have raised debate over this country's policies and programs for disabled workers. Central to the discussion are economic issues that have not been well understood, and it is these issues that are addressed by **Disability and the Labor Market.**

The contributors analyze the economic forces that determine whether or not a disabled person enters the workplace: incentives and disincentives in the social security and workers' compensation systems, the job market for disabled workers, employer accommodation, employment alternatives, and the effects of anti-discrimination legislation.

Chapters include: 1) Disability and the Labor Market: An Overview by Monroe Berkowitz and M. Anne Hill; 2) Social Security Disability Policy in the 1980s and Beyond by Carolyn L. Weaver; 3) Labor Supply Incentives and Disincentives for Disabled Persons by Jonathan S. Leonard; 4) Some Lessons From the Workers' Compensation Program by John D. Worrall and Richard J. Butler; 5) Workers' Compensation and Employment: An Industry Analysis by James Lambrinos and David Appel; 6) The Economics of Transitional Employment and Supported Employment by Craig Thornton and Rebecca Maynard; 7) The Economics of Job Displacement by Robert S. Smith; 8) The Role of Reasonable Accommodation in Employing Disabled Persons in Private Industry by Frederick C. Collignon; 9) The Rehabilitation Act and Discrimination Against Handicapped Workers: Does the Cure Fit the Disease? by William G. Johnson; and 10) Disability Policy in the United States, Sweden, and the Netherlands by Richard V. Burkhauser.

Disability Expenditures 1970-1982, by Monroe Berkowitz, Rutgers University, Bureau of Economic Research, New Brunswick, NJ 08903, U.S.A., January 1985, 63 pp.

This is a report on U.S. disability expenditures from 1970 to 1982 in three major categories: transfers, medical care costs and direct services. Calculations are based on payments which would be eliminated if disabilities were not a part of the picture.

The Disability System: A Dynamic Analysis by Edward J. Hester, Director of Research and Paul G. Decelles, Research Associate, The Menninger Foundation, Center for Applied Behavioral Sciences, Division of Rehabilitation Programs, Research and Training Center, Jayhawk Tower, 700 Jackson, 9th floor, Topeka, KS 66603, U.S.A., February 1985, 92 pp., reprint $5.00.

This paper demonstrates the utility of the Menninger model in understanding the disability system through the use of actual data. It also illustrates how the model can be used to project the effect of various societal changes upon the disability system as well as how it can be used to simulate the effects of various program and policy strategies.

Disabled Persons Income in New Zealand, by Ms. Fiona Chee and Sue Henderson, commissioned by the Executive Committee of Disabled Persons Assembly (NZ) Inc., P.O. Box 27-186, 63 Hankey Street, Wellington, N.Z. on behalf of the Income Portfolio Holder Mr. D. McKenzie, published 1985, 66 pp.

The policy goals of the Disabled Persons Assembly (D.P.A.) are to achieve equity, dignity, justice, equal opportunity and participation for all disabled persons. A major goal is to seek the establishment of an income system that will assist people to live independently in the community with a life style that is equal to the rest of the community. This report is prepared with these goals in mind. Specifically, the aim of the present report is to examine the adequacy and equity of financial provision for disabled persons in relation to everyday living at the present time.

Economics and Equity in Employment of People with Disabilities: International Policies and Practices. Proceedings from the Symposium: April 28-May 2, 1984, edited by Rochelle V. Habeck, Donald E. Galvin, William D. Frey, Linda M. Chadderdon, Denise G. Tate, Michigan State University, published 1985 by University Center for International Rehabilitation, Michigan State University, 513 Erickson Hall, East Lansing, MI 48824-1034, U.S.A., 230 pp.

The Symposium covered the following topics:

1. An Overview of Policy Issues, with articles on U.S.A., U.K.
2. Employer Initiatives—Policy Approaches, with articles on U.S.A., Finland.
3. Employer Initiatives—Policy Implementation, with articles on U.K., U.S.A., Federal Republic of Germany, Sweden.
4. Government Initiatives, with articles on U.S.A., Federal Republic of Germany, Japan, Canada, Netherlands.
5. Partnership Initiatives, with articles on U.S.A., Sweden, France, U.K., Australia.
6. Symposium Outcomes and Recommendations for the Future, with articles on U.S.A., Sweden.

The Economic Integration of the Disabled: An Analysis of Measure and Trends in Member States, Commission of the European Communities, published 1984, Office of Official Publications of the European Communities, Luxembourg, ECU 18.73, BRF 850, IRL 13.60, UKL 11.10, US $14.

This consolidated report is in two parts. Part one of the report adopts both a systematic and systemic approach. The systematic approach to the main problems encountered by the disabled in the process of vocational integration covers: nature of the handicap, its origin and the method of evaluation; open, sheltered and alternative employment; individual guarantees; institutions responsible for employment; financial and technical aid to promote employment; and the representation of disabled workers. The systematic approach identifies and clarifies the reasons for the success or shortcomings of various social policies on the employment of the disabled.

Part two is based on an analysis of the discussions and contacts with people and institutions directly involved in the problems of the disabled, and on sifting through the documentation furnished at European and national levels. In this part, the approach is global. It suggests the theoretical framework for a comparative assessment of the main guidelines noted within Member States.

The Economics of Transitional Employment and Supported Employment by Craig Thornton, Senior Economist, and Rebecca Maynard, Vice President and Deputy Director of Research, Mathematica Policy Research, Inc., P.O. Box 2393, Princeton, NJ 08540, U.S.A., March 1985, 37 pp.

The purpose of this paper is to offer an economic assessment of the two program models (transitional and supported employment) by exploring the rationale that underlies these direct government interventions and by examining existing evidence on their economic efficiency and equity—that is, whether they offer the potential for generating impacts that are sufficiently large to outweigh their costs. The assessment is begun first by defining the transitional and supported employment models, and then by examining the specific problems addressed by transitional and supported employment and why they represent appropriate types of interventions. The crux of the paper analyzes the potential of transitional and supported employment for enhancing the employment prospects for disabled persons. We consider the existing evidence on the feasibility of these programs, their costs, the potential magnitude of their impacts, and the types of intangible benefits they may generate. Focus is on the potential of the programs, rather than on their actual performance, because currently available evaluations provide insufficient evidence to estimate the impacts of the programs.

The Effectiveness of Vocational Rehabilitation Services with the SSDI Recipient by Edward J. Hester, Director of Research and Gabriel R. Faimon, Director, The Menninger Foundation, Center for Applied Behavioral Sciences, Division of Rehabilitation Programs, Research and Training Center, Jayhawk Tower, 700 Jackson, 9th floor, Topeka, KS 66603. U.S.A., May 1985, 59 pp., reprint $5.00.

Almost all workers who become disabled are eligible to apply for Social Security Disability Insurance (SSDI) benefits, for approximately 95% of the United States work force is covered by this program. A major question is effectiveness of vocational rehabilitation (VR) services to get SSDI beneficiaries to respond to return to work efforts. This report presents an analysis of those persons in Illinois who were allowed or denied SSDI benefits and whose vocational rehabilitation case files were closed during fiscal years 1979 through 1983. Referral, feasibility for VR services, and outcomes were correlated to a number of demographic variables including age, sex, race, and disability. The authors conclude that those SSDI recipients who are referred to VR services are significantly different from the general population of those allowed SSDI benefits and that an improved method of referral for those recipients having rehabilitation potential needs to be developed.

Guides to the Evaluation of Permanent Impairment. 2nd edition. American Medical Association, Book and Pamphlet Department, 535 North Deaborn Street, Chicago, IL 60610, U.S.A., 1984, 245 pp., $27.50 hardcover.

The principal objective of the Guides is to define as precisely as possible the meaning of medical and nonmedical statements that are made by physicians about individuals whose health is impaired, and the ways in which these statements are understood and used. The purpose of the Guides is to make clear these distinctions in such a way as to meet the needs of all people whose health impairments have caused impairment of their capacities to engage in their activities of daily living and to meet their personal, social, or occupational demands.

Federal Spending for Mental Retardation and Developmental Disabilities, by David Braddock, Ph.D., published 1985 by Institute for the Study of Developmental Disabilities and School of Public Health, University of Illinois at Chicago, 1640 West Roosevelt Road, Chicago, IL 60608, U.S.A., 284 pp.

This working paper is both an analysis of contemporary Federal spending policies in mental retardation and an archival reference document. It was developed for policymakers, professionals, parents and graduate students who seek a deeper understanding of the Federal role in financing services, training, research, income maintenance, and the construction of facilities for persons with mental retardation or related developmental disabilities.

The first two chapters, which constitute Part One of the monograph, provide a nontechnical overview of the history of Federal aid in the MR/DD field. Chapters 3-8 (Part Two) present in-depth profiles of each individual MR/DD program element supported by the Federal Government since 1935. There are 82 such profiles containing comprehensive information on the element's statutory history, funding record, and programmatic accomplishments. An analysis of overall Federal MR/DD spending trends is in Chapter 9 and a reference section features bibliographical citations and key Federal agency respondents involved in the study.

Implications of Benefit-Cost Analysis for State Vocational Rehabilitation Agencies by Dale Hanks, Virginia Department of Rehabilitative Services, a discussion prepared for National Advisory Committee to an NIHR Project: Enhanced Understanding of the Economics of Disability, January, 1985, 6 pp.

Currently, the conventional State-Federal vocational rehabilitation system may be described as a "black box" because of our lack of knowledge about the relationships among client characteristics, services provided, and client outcomes. We are seeking a model which will help us better understand what goes on during the rehabilitation process. The main idea in benefit-cost analysis is to make policy decisions about resource allocations with better information concerning the relationships among client characteristics, services provided, and client outcomes. Benefit-cost analysis in vocational rehabilitation is not new, but rather our modern approach to it is new and quite sophisticated compared with previous times.

Income Transfers for Families With Children: an Eight-Country Study, by Alfred J.

Kahn and Sheila B. Kamerman, School of Social Work at Columbia University, published 1983 by Temple University Press, Philadelphia, PA 19122, U.S.A., 353 pp.

This volume reports for the first time on the relative generosity of eight western industrial societies in responding to the economic needs of families with young children. Special attention is given to the ways in which specific programs are responsive to variations in family composition, to the degree to which countries are generous or not generous to different types of families. The individual programs discussed include social insurance, family allowance, public assistance, personal income tax, housing allowances, food stamps, and other programs unique to particular countries.

The countries discussed are: Australia, Canada, the Federal Republic of Germany, France, Israel, Sweden, the United Kingdom, and the United States.

Inventing a Future for Work Disabled Individuals: Strategic Thinking for American Health and Disability Policy to the 21st Century by R. Alexander Vachon, III, Switzer Distinguished Fellow, National Institute of Handicapped Research, U.S. Department of Education, Washington, D.C. 20202, U.S.A., September 1985, 60 pp.

The central argument developed in this paper is that until health and disability management are seen as one system, with a common set of goals, and the natural boundaries for discussion of all health and disability issues (including apparently unrelated subjects as health research expenditures and occupational disease liability), we will not have a fruitful and satisfying prospectus for health and disability care for the last quarter of the 20th century.

More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries, 1981, report to the Congress of the United States by the Comptroller General, U.S. General Accounting Office, Document Handling and Information Services Facility, P.O. Box 6015, Gaithersburg, MD 20760, U.S.A., 31 pp.

This report discusses the need for the Social Security Administration (SSA) to follow up on disability beneficiaries to determine their continued eligibility. It shows that as many as 584,000 title II disability beneficiaries may be ineligible for program payments totaling $2 billion annually, and it contains recommendations for SSA to take immediate action to reduce the number of ineligible recipients.

MRD: Minimal Record of Disability for Multiple Sclerosis, developed by International Federation of Multiple Sclerosis Societies, published by National Multiple Sclerosis Society, 205 East 42nd Street, New York, NY 10017, U.S.A., 1984, 47 pp.

This Minimal Record of Disability for Multiple Sclerosis was prepared under the aegis of the Society. The format combines neurological assessment and status of daily living circumstances in a single-page progress note that can be completed in a few minutes and computer coded. Two-thirds of the interview and examination can be performed by an allied health professional. This should act as an aid to private and governmental agencies who are putting increased emphasis on quantitative assessment and reporting for disability and insurance reimbursements.

Predicting Which Disabled Employees Will Return to Work: The Menninger RTW Scale by Edward J. Hester, Director of Research, Paul G. Gecelles, Research Associate and Edwin L. Gaddis, Research Associate, published 1986 by The Menninger Foundation, Will Menninger Center for Applied Behavioral Sciences, Division of Rehabilitation Programs, Research and Training Center, Jayhawk Tower, 700 Jackson, 9th floor, Topeka, KS 66603, U.S.A., 85 pp.

This report was compiled from information from a major insurance carrier on 600 Long Term Disability claimants. Half of these people returned to work, while the other half did not. These data were analyzed to determine which items distinguished the two groups.

Ten items were found to differ significantly between those workers who returned to work and those who did not. These items were combined to form the Menninger RTW Scale which indicates the likelihood of a disabled person returning to work without rehabilitation assistance.

Social Expenditure 1960-1990. Problems of Growth and Control, published 1985 by Organisation for Economic Co-operation and Development, 2, rue Andre-Pascal, 75775 Paris Cedex 16, France, 97 pp., $15.00 soft cover.

This report, which begins a series of OECD Social Policy Studies, is concerned with the growth of social expenditure, the determinants of that growth and prospective medium-term expenditure developments. Detailed statistics are provided for expenditure in Education, Health Care, Pensions, and Unemployment Compensation for each OECD country.

Social Security Disability: Past, Present and Future, an information paper prepared by the staff of the Special Committee on Aging, United States Senate, U.S. Government Printing Office, Washington, D.C. 20402, U.S.A., 1982, 39 pp.

The Special Committee on Aging has conducted a staff study of this program and produced this report for the use of those who are interested in better understanding this complex yet critically important program. Proposals have been advanced to change the disability program in a variety of ways, in the hope of improving the administration of the program and of delivering fair and consistent determinations of disability.

Special Measures Provided by Social Security Institutions to Permit and Facilitate the Independent Living of Disabled Persons, by O. Geiecker, Assistant Director-General, General Institute for Insurance against Employment Accidents and Occupational Diseases, Federal of Austrian Social Insurance Institutes, report of the Study Group on Rehabilitation, XXIst General Assembly, International Social Security Association, 1983, 94 pp.

This is a study of those special measures taken by social security organizations which complement ordinary benefits, to permit and facilitate an autonomous lifestyle for the disabled. The difficulties foreseen in carrying out this study have been offset by providing a detailed definition of the concept "independent living of disabled persons" and by means of a comprehensive list of examples of possible special measures.

Brief descriptions of national monographs are included from the following countries: Australia, Austria, Canada, Finland, France, the Federal Republic of Germany, Hungary, Israel, Ivory Coast, Norway, USSR, United Kingdom, United States, Venezuela.

The Study of Social Policy: A Comparative Approach, by Barbara Rodgers, Policy Studies Institute, London with Abraham Doron, the Paul Baerwald School of Social Work, the Hebrew University of Jerusalem and Michael Jones, Australian Centre for Local Government Studies, Canberra College of Advanced Education, published by George Allen & Unwin Ltd., 40 Museum Street, London WC1A 1LU, United Kingdom, 232 pp.

The book opens with a full and stringent treatment of methodological problems, moves on to suggest how they can be tackled, and sets up a conceptual and analytical framework for four case studies and the comparative analysis arising out of them. A final section, Reflections, looks back on the whole exercise and considers how far the comparative approach can help to deepen our understanding of the nature of the personal social services and social work, of their particular contribution to broader welfare objectives, and of the seemingly inherent problems which arise in their implementation.

The Supplemental Security Income Program for the Aged, Blind, and Disabled: Characteristics of State Assistance Programs for SSI Recipients, January, 1986, published by The Social Security Administration, Office of Supplemental Security Income, Division of Program Management and Analysis, Program Planning, Research, Analysis and Projections Branch, 6401 Security Boulevard, Baltimore, MD 21235, U.S.A., 117 pp.

This report provides data on selected characteristics of State assistance programs for SSI recipients as of January 1, 1986. State payments under these programs supplement those received under the Federal supplemental security income (SSI) program. The characteristics selected are those that the Social Security Administration has most frequently received inquiries about from individuals, public and private institutions, and Federal and State agencies. It focuses on eligibility provisions and basic levels of assistance for individuals and couples who receive supplementary payments in each State and in the District of Columbia. Data are also presented on Federal-State administrative responsibilities for making payments, on State criteria for special need payments, and on Medicaid eligibility.

Welfare Bureaucracies: Their design and change in response to social problems, by David Billis, Brunel University, published 1984 by Heinemann Educational Books Ltd., 22 Bedford Square, London SC1B 3HH, United Kingdom and Gower Publishing Co., Old Post Rds., Brookfield, VT 05036, U.S.A. 252 pp., $23.95 soft cover.

This book aims to provide students, policy-makers and practitioners with a usable theory: theory to understand, design and change welfare bureaucracies.

David Billis begins by criticising the 'schizophrenic' approach of social administration in its unwillingness to study bureaucracy. He offers instead a problem-oriented approach both to the philosophy of organizations and to methodological issues. He then challenges many entrenched beliefs (for example, about 'social distress', 'prevention', 'delegation' and 'authority') and presents alternative models and concepts. Finally, he uses case studies to show how usable theory can be developed and applied in order to close the gap between theory and practice.

The Worker Who Becomes Physically Disabled: A Handbook of Incidence and Outcomes, by Edward J. Hester, Director of Research and Paul G. Decelles, Research Associate, published 1985 by The Menninger Foundation, Will Menninger Center for Applied Behavioral Sciences, Division of Rehabilitation Programs, Research and Training Center, Jayhawk Tower, 700 Jackson, 9th floor, Topeka, Kansas 66603, U.S.A., 127 pp.

This handbook attempts to provide a database for analysis and simulation in order to develop programs and policies which will lessen the financial dependence of disabled workers who are still capable of gainful employment. This will be done by using disabilities grouped by three methods. The first grouping is based upon the three entrance routes to the system: progressive physical disability, acute physical disability, and injury. The second classification system is that used by the Merck Manual which is essentially based on the bodily system affected. There were sufficient data available to analyze the incidence and outcomes for eleven classifications. Finally, six more specific disability groupings, such as cancer, arthritis, and cardiac problems are looked at.

World Bibliography of Social Security, published twice yearly by the International Social Security Association, annual subscription Sw. Fr. 50, English, French, German and Spanish.

This Bibliography provides references to recent publications relating to the different branches of social security and other principal forms of social protection. References are classified by country in the alphabetical order of the ISO (International Standardisation Organisation) code. An international section completes the country listing. For each country the titles appear under the social security branch or other form of social protection to which they refer. A subject index appears at the end of the Bibliography.

Conference Papers

Creation of an Economic Climate Favourable to the Employment of Young Disabled Persons, by Dieter Eichner, Federal Employment Institute, Federal Republic of Germany, report of the ISSA Expert group meeting on social security and rehabilitation measures for the young disabled, Lisbon, May 1985, 12 pp.

The purpose of this report is to explain why in the Federal Republic of Germany specifically targeted social and labour market assistance for vocational rehabilitation is given such importance in relation to the improvement of employment opportunities and is handled by an institution which is both the labour administration *and* a rehabilitation authority; and why the acquisition of a vocational qualification is so important, particularly for the young disabled, in order that they can achieve their potential through productive work.

Disabled Youth in Normal Society—A Discussion of Some of the Results of an On-going Research Process, by Kari Marie Helle, Institute of Work Psychology, Oslo, Norway, report of the International Social Security Association Expert group meeting on social security and rehabilitation measures for the young disabled, Lisbon, May 1986, 13 pp.

The research objective which forms the basis for this paper is to assess the likelihood that the struggle for equal opportunities will succeed. The main concern is to establish a research process that will generate resources which the disabled themselves can utilize in a meaningful way. Integration research calls for methods that enable the disabled to define their problems and to act as partners in the research process. The study covers social theory and modern integration concepts, occupational integration, integration research in a local district and conclusions.

An Economic Analysis of the Laws Promoting Employment of Handicapped Persons by William G. Johnson, Professor of Economics, Department of Economics, The Maxwell School, Syracuse University, Syracuse, NY 13210, paper prepared for the National Conference on the Economics of Disability, Washington, D.C., U.S.A., April 9-10, 1985, 40 pp.

There are six sections in this paper. The first defines terms. The second section describes three sources of economic discrimination and reviews the empirical research on discrimination against handicapped workers. Gains in efficiency that might be obtained by reducing discrimination are the subject of the third section. The effectiveness of market incentives in reducing discrimination is discussed in section four. Government intervention, as a solution to discrimination, is discussed using the example of the Rehabilitation Act of 1973 in the fifth section of the paper. Conclusions and suggestions for further research are presented in section six.

An Industry Perspective on the Management of Disability at the Workplace by Paul S. Entmacher, M.D., Vice President and Chief Medical Director, Metropolitan Life Insurance Company, paper presented at the International Conference on Innovations in the Management of Disability at the Workplace, November 7, 1985, 8 pp.

This paper presents thoughts from the perspective on rehabilitation, employment practices and disability management as it concerns several facets of the insurance industry. It summarizes by saying that while the successes of returning employees to the workplace are increasing impressively, much remains to be accomplished but the pathway that needs to be taken is clearer than ever. There is no doubt that more and more companies will be developing rehabilitation programs to help disabled workers return to gainful employment. The author foresees a partnership with group policyholders and rehabilitation professionals which will mark a turnaround in disability management.

Long-Term Care: American Problems and Foreign Solutions by William A. Glaser, Graduate School of Management and Urban Professions, New School for Social Research, Department of Health Services Administration, 66 Fifth Avenue, New York, NY 10011, U.S.A., paper prepared for the Select Committee on Aging, United States House of Representatives, July 1985, 26 pp.

Long-term care of the elderly baffles every developed country at present. America's problems are universal. Sharing experiences across countries reveals a number of suggestive approaches abroad that the United States might emulate. But America has been quite inventive as well, and sharing enables other countries to learn too. This paper gives some impressions of how other developed countries have tried to solve the problems of long-term care of the elderly.

Rehabilitation Measures and Social Security for the Young Disabled, by A. Huunan-Seppala, S. Laaksovirta and R. Raitasalo, Social Insurance Institution, Finland, report of the International Social Security Association Expert group meeting on social security and rehabilitation measures for the young disabled, Lisbon, May 1986, 16 pp.

In developing rehabilitation for the young disabled (16-24 years old), besides planning a system of services, an attempt should be made to understand the special rehabilitation requirements which arise as a result of young people's stage of psychological development. An underlying principle of rehabilitation measures carried out during youth should be the provision of adequate emotional support in a manner which takes account of the special features of the stage of development. The study covers the concept of rehabilitation of the young, prevalence of disability among the young and their need for rehabilitation, general considerations for rehabilitation and social security and a system-oriented description of social security and rehabilitation for the young disabled in Finland.

Rehabilitation of the Young Disabled in Portugal, by National Secretariat for Rehabilitation, Portugal, report of the International Social Security Association Expert group meeting on social security and rehabilitation measures for the young disabled, Lisbon, May 1986, 16 pp.

The purpose of this paper is to review the mainlines of the services provided to the young disabled and to explain the principal guidelines governing the rehabilitation policies of the National Secretariat for Rehabilitation (SNR). It also gives a brief description of the role of the Departments of Education, Labour and Social Security in the rehabilitation of disabled youth, focusing on areas where a strengthening of the existing means of encouraging social integration would seem most desirable.

Social Security and Insecurity: Young People with Disabilities in the United Kingdom, by Michael Hirst, Social Policy Research Unit, University of York, United Kingdom, report of the International Social Security Association Expert group meeting on social security and rehabilitation measures for the young disabled, Lisbon, May 1986, 15 pp.

This paper is primarily concerned with income security arrangements in the United Kingdom for young people with severe disabilities. The aim is to examine major issues of concern arising from current provision and to identify basic principles for income security policies for disabled young people.

This paper is divided into four main sections; the first describes social security provision for disabled young people in the United Kingdom. In the second section, the implications of income security arrangements for the vocational decisions made by or on behalf of disabled young people are examined. The third section looks at the effects of income security arrangements on young people's growing independence. A final section suggests some basic principles which should inform of income security provision for young people with disabilities.

Social Security and Rehabilitation Measures for the Young Disabled in Israel, by Nira Shamai, National Insurance Institute, Israel, report of the International Social Security Association Expert group meeting on social security and rehabilitation measures for the young disabled, Lisbon, May 1986, 10 pp.

Because of the nature of eligibility criteria and the gradual development of social insurance programs, coverage of younger disabled individuals aged 15-24 is divided among the various programs. In general, persons aged 18-24 are covered in the same manner as the rest of the insured population according to the circumstances of disability. However, several specific provisions exist for disabled youth under age 18, aimed at meeting the special needs of the younger disabled and their families. This report details these provisions.

Social Security for Families with Young Mentally Disabled Members in Two Different Socio-Political Systems—A Comparison Between the Federal Republic of Germany and Denmark, by Rainer Wedekind, Department of Psychiatry and Neurology, State Hospital of Westphalia, Gutersloh, Federal Republic of Germany, report of the International Social Security Association Expert group meeting on social security and rehabilitation measures for the young disabled, Lisbon, May 1986, 15 pp.

The effects of social support provisions on living conditions were assessed by questioning families with mentally handicapped children and young persons in two clearly defined regions, Denmark and North Germany. The results of this survey provided information on the living conditions of the families concerned at two levels of comparison: 1) additional burdens, and relief through social provisions, which lead to differences in the living conditions of families with mentally handicapped children and young persons as compared with those of families with non-handicapped children (comparison of living conditions) and 2) the effect of supporting measures for the families concerned under a system of social security where provisions are based on the principle of normalisation, in comparison with the effects of the support provided under the articulated system of social security in the Federal Republic of Germany (analysis of social policy effects).

The Swedish Disability Policy by Eskil Wadensjo, Swedish Institute for Social Research, paper presented for Expert meeting on Vocational Rehabilitation of Disabled Persons, Warsaw, November 12-18, 1984, arranged by United Nations European Social Development Programme, 21 pp.

The paper covers 1) The Development of the Swedish Disability Policy; 2) The Swedish Disability Policy Now; 3) The Growth and the Causes of Growth of Disability Policy; 4) Effects on Labor Supply; 5) Disability Policy and Equity; and 6) Integration or segregation of the Disabled in the Labor Market.

United States Disability Policy: An Analysis Within the Context of the European Experience by Richard V. Burkhauser, Vanderbilt University, paper prepared for the Conference on the economics of Disability, Washington, D.C. March 7, 1985, 34 pp.

In this paper the two most comprehensive disability systems in Western Europe, those of Sweden and the Netherlands, are described and compared to that of the United States. As in this country, during the 1970s both European countries dramatically increased expenditures on disability programs and experienced rapid increases in the population of disability income transfer recipients and in government-supported work for the disabled. Yet the reliance on these two program responses—income support and employment—among the three countries differed significantly, as did the response of government policymakers to the added budgetary costs generated by these programs.

Section I discusses the goals of disability policy and the approaches used by Sweden and the Netherlands to achieve them over the past decade and a half. Because of the complexity of programs which touch the disabled, only the principal disability transfer and work programs are considered. Section II reviews, within the context of the European experience, the magnitude and direction of change in United States programs in the early 1970s and the subsequent responses of policymakers to this change. Section three evaluates the success of policy in achieving its stated goals in the three countries and speculates on prospects for further change in the second half of this decade.

"Unemployment and Disability: Some Sociological Aspects of Elimination from the Labour Market" by Raija Gould, Central Pension Security Institute, Finland.

This paper presents certain regional and temporal correlations between the frequency of disability and unemployment, and it also describes some manifestations of these correlations on an individual level. The perspective of the paper is dynamic. It attempts to elucidate the integrated problems of unemployment and disability from a developmental point of view: the contents, extent and meaning of the present concepts of unemployment and disability have been shaped alongside changes in working life, changes in the patterns of illness and, finally, changes in the social security system.

Worknet: Modeling the Compensation and Rehabilitation Systems for the Disabled Population by Alexander H. Lewis, Anne Claire Louvet, Karen Heise and Ilze S. Levis, The Menninger Foundation, Center for Applied Behavioral Sciences, Division of Rehabilitation Programs, Research and Training Center, Jayhawk Tower, 700 Jackson, 9th floor, Topeka, KS 66603, U.S.A., October 1984, 77 pp., reprint $5.00.

A quantitative methodology for describing the compensation and rehabilitation systems for the disabled is presented. A flow graph representation is used to trace the flow of cases through the Determination and Appeals process of SSDI and through the Illinois Vocational Rehabilitation system. Projections of the disabled population (by age, sex, and race) at the national level and for the state of Illinois up to the year 2000 were made for use with the models. A data base system was designed to support the models and to present the results of the analysis.

Journal Articles

"Assessing Health Hazards in the Work Place", by Michael S. Brown, Manager of the Small Quantity Generator Program in the Office of Safe Waste Management, Massachusetts Department of Environmental Management, Boston, Massachusetts, *Business and Health*, Vol. 3, No. 10, October 1986, pp. 14-18.

With new products and processes being introduced regularly, uncertainties remain in defining the relationship between work and disease. Brown calls attention to the fact that workers' perceptions of risk may have a significant effect on their organization, citing a 1984 study on "Workers at Risk: Voices from the Workplace".

"A 10-Year Review of the Supplemental Security Income Program", by John Trout and David Mattson, Office of Legislative and Regulatory Policy, Office of Policy, Social Security Administration, *Social Security Bulletin*, U.S. Department of Health and Human Services, Social Security Administration, Vol. 47, No. 1, January 1984, pp. 3-64.

This article looks at the SSI program in the context of the program's goals as set out by Congress and discusses the legislative changes—and the motives behind those changes—since its implementation. Statistical data are examined to determine whether the program is accomplishing what it was designed to do, and whether, as a result of legislation or because of changes in the characteristics of the recipient population, trends are developing that may have a future impact on the program.

"Compensation for personal injury under social security", by Arye L. Miller, Research Professor, Harry Sacher Institute for Legislative Research and Comparative Law, Jerusalem, *International Labour Review*, 1985, Vol. 124, No. 2, pp. 193-205.

The society in which we live today presents new dangers—traffic accidents, industrial pollution, harmful products, medical errors, crime—such as to warrant a revamping of social security compensation for personal injury towards meeting the real needs of the population. The author argues that schemes need to be established that will guarantee all victims of personal injury, whatever its origin, the same benefits and the same level of protection under conditions that are identical for all. The argument is illustrated by the solutions adopted by the

Netherlands and New Zealand under innovative social security legislation.

"Determining Cost Benefits of Worksite Wellness", by Dave Patterson, Manager of the health/safety promotion department, United Methodist Publishing House, Nashville, TN, *Business and Health*, Vol. 3, No. 10, October 1986, pp. 40-41.

The development of worksite wellness programs recently has come under attack due to the fact that the costs associated with, including exercise clothes, equipment, facilities, training and time, have not decreased, but rather have added to the nation's health expenditures. Patterson reports on the experience of one employer, United Methodist Publishing House, who has instituted a comprehensive health enhancement and accident prevention program that may be linked to company savings in health care and absenteeism costs.

"Disability Management: A Comprehensive Framework for Prevention and Rehabilitation in the Workplace," by Denise G. Tate and Rochelle V. Habeck, Rehabilitation Counseling Program, Michigan State University and Gail Schwartz, Institute of Rehabilitation and Disability Management, *Rehabilitation Literature*, Vol. 47, No. 9-10, September-October, 1986, pp. 230-255.

As employers began to realize that healthy employees represent an investment and a resource to the organization, preventing and managing disability have become a more central concern. This concern led to the fast expansion of health promotion disability management programs, employee assistance programs, and transitional work programs to meet the challenge of effective cost management. This article defines these programs, presents an example of a U.S. company that is currently adopting these approaches, and discusses implications vis-a-vis future trends and current concerns.

"Disability Policy," by Howard S. Erlanger, University of Wisconsin, Madison and William Roth, State University of New York, Albany, *American Behavioral Scientist*, Vol. 28, No. 3, January/February 1985, pp. 319-345.

To facilitate the task of evaluating the whole of disability policy, the legislative development of its subparts is first considered. The purpose here is to show that existing policy is a diverse set of minipolicies, diverse in the perceived needs it addresses, in the groups it seeks to benefit, in its legislative origins and purposes, and in the interest groups that battled over its enactment. Following the examination of the component parts of disability policy, we return to a consideration of the aggregate and consider the common elements and changing focus in disability policy as a whole. Here it is found that in spite of the varied origins and purposes of disability policy, there has been, until recently a common thread to it in that it has been oriented toward income maintenance and minimal rehabilitation of disabled people rather than toward removal of the causes of disability, removal of structural barriers to the employment of disabled people, or integration of disabled people into the mainstream of society.

"Disability prevention and vocational rehabilitation of the disabled in the Byelorussian SSR", by G. A. Kriulin, Minister of Social Security, Byelorussian SSR, *International Labour Review*, Vol. 125, No. 2, March-April 1986, pp. 209-225.

This article discusses disability prevention and vocational rehabilitation in the Byelorussian SSR both historically and in the present and future. Topics include: 1) Disability trends in the BSSR; 2) State measures to promote social and vocational rehabilitation; 3) Pensions, privileges and advantages for the disabled; 4) Industrial medical boards; 5) Organization of training and retraining for the disabled; and 6) Recent measures to promote disability prevention and rehabilitation of the disabled.

"Emotional disorders and the labour force: Prevalence, costs, prevention and rehabilitation", by Mary A. Jansen, Dean for Professional Affairs, California School of Professional Psychology, Fresno, California, article for the *International Labour Review*, Vol. 125, No. 5, September-October 1986, pp. 605-615.

Estimates of the prevalence of emotional disorders among members of the labour force vary, but it is generally agreed that a high percentage experience some form of emotional disturbance at some time during their working lives. This article discusses this issue and outlines some steps that have been taken to combat the problem in the United States.

"Employee Health Decisions: Process Not Event", by Gerald W. Bush, Heller Graduate School At Brandeis University, Waltham, Massachusetts, *Business and Health*, Vol. 3, No. 1, November 1985, pp. 24-26.

Business decision making in employee

health matters requires more than technical competence and careful analysis. In today's occupational environment, what is needed is a complex multidisciplinary team approach that is difficult to manage and hard to project. This article discusses the issue of how a company can cope with complex decisions about possible employee exposure to health hazards and still remain productive and competitive in domestic and international markets.

"Financing Long-Term Psychiatric Care", by Howard H. Goldman, consultant to the National Institute of Mental Health in Rockville, MD and director of mental health policy studies at the University of Maryland Medical School, Baltimore, MD, *Business and Health*, Vol. 3, No. 4, March 1986, pp. 5-7.

This article discusses the complex problems of long-term care financing for chronic psychiatric conditions. The expense is great and the desire to not think about the need or the inclination to pass the responsibility to another payer is even greater. Goldman feels that consideration of these issues will contribute to the public good as well as serve the private interests of business in its efforts to control costs and meet the needs of management, employees and their dependents.

"Forestalling Disincentives to Return to Work", by Monroe Berkowitz, Rutgers University, New Brunswick, NJ, *Business and Health*, Vol. 2, No. 4, March 1985, pp. 30-32.

According to the author, disincentives to return to work do exist, and changes in SSDI benefit laws and the use of medical definitions of disability encourage them. However, employers can have an increasingly important role in lessening these conditions. Specifically, an effective work place program requires: 1) An analysis of short-term disability records together with associated records; 2) The assignment of knowledgeable personnel to investigate potential problem situations and to recommend job changes where indicated; 3) A knowledge of the physical and mental requirements of individual jobs; and 4) The existence of a transfer policy, transitional work program or enclave where workers can be placed with minimal productivity disruptions.

"Health Care Foundations Take Long-Range View, says Aiken" by Jane Stein, editor, *Business and Health*, Vol. 2, Number 10, October 1985, pp. 46-49.

Last year, The Robert Wood Johnson Foundation supported $60 million worth of health care programs and research, most of which focused on new and cost-effective ways of providing services. Increasingly, the foundation is reaching out to the business community, as, for example, in the community programs for affordable health care, which involve hospitals, insurers and employer groups. Linda H. Aiken, Vice President in charge of evaluating the foundation's projects, was interviewed about the role of foundations in funding solutions to critical issues.

"Health Promotion, Disability Management, and Rehabilitation in the Workplace", by Donald E. Galvin, National Rehabilitation Hospital and the Institute for Rehabilitation and Disability Management, *Rehabilitation Literature*, Vol. 47, No. 9-10, September-October, 1986, pp. 218-223.

Employer-based health promotion, disability management, and rehabilitation initiatives emphasize the early identification of health risk factors, the management of physical symptoms, planned management of disability-related costs, a willingness to modify jobs, and the establishment of personnel policies that facilitate work return and job retention rather than defacto and premature retirement for chronically ill, injured, or disabled workers.

This article discusses industry-based efforts to improve the quality of work life through various worker investment schemes.

"Home Care for Life-Supported Persons in France: The Regional Association", by Allen I. Goldberg, Medical Director, Division of Respiratory Care, Children's Memorial Hospital, Chicago, IL and Eveline A.M. Faure, Department of Anesthesiology, Pritzker School of Medicine, University of Chicago, *Rehabilitation Literature*, Vol. 47, No. 3-4, March-April 1986, pp. 60-62.

Home care for persons who depend upon life-supportive technology creates a challenge for analysis and planning. As a case example, the ventilator-dependent patient raises issues that require public-private-voluntary sector interaction for realistic and workable solutions. France provides an established model for study. The French regional associations are home ventilator care systems that have met the multiple needs of those concerned. Operational home care concepts abroad exist for our scrutiny as we in the United States plan pioneering efforts in this field.

"Industrial Rehabilitation at Kodak", by Robert H. Jones, Corporate Rehabilitation Consultant, Eastman Kodak, Rochester, New York, *Business and Health*, Vol. 3, No. 2, December 1985, pp. 26-28.

Industrial rehabilitation is a process that deals with chronic medical problems that produce long-term interference with job performance. It attempts to increase a person's capacity whenever practical, to identify his or her assets with the most potential for high productivity, to match his or her capacity to job demands, and to assure that the match is realistic and workable. Eastman Kodak's successful program of industrial rehabilitation is discussed in depth in this article.

"Managing Benefit Costs With Disability Claims Audits", by Richard Lewis, President, Thomas L. Jacobs & Associates, Inc., Chicago, IL, *Business and Health*, Vol. 2, No. 4, March 1985, pp. 33-36.

Claims auditing is one technique that can be employed to evaluate all types of disability income programs, including sick leave, short- and long-term disability, disability retirement and workers' compensation programs, and to identify administrative and plan design opportunities for controlling costs. A disability audit contains three basic parts: 1) A review of disability plan provisions, and the procedures and materials used in plan administration; 2) A detailed audit of selected representative claims; and 3) Data tabulation and analysis.

An audit not only helps reduce benefit abuse, but also can lead to an improved use of tools such as rehabilitation and limited duty programs. The key is for employers not to relinquish control of these programs to their disability claims administrator. This will inevitably lead to higher and higher costs. Employers must use tools such as the claim audit to enforce quality performance by their administrators.

"Material benefits and services provided to workers in the USSR by social insurance in case of temporary incapacity for work", by G. S. Simonenko, Deputy Chief, State Social Insurance Department, All-Union Central Council of Trade Unions, USSR, *International Social Security Review*, 4/85, International Social Security Association, Geneva, pp. 387-395.

Soviet social insurance is characterized by the variety of its forms and the systematic expansion of its benefits. The system currently in operation provides practically all forms of benefits recognized throughout the world. Besides this, there are other forms of benefit which are unique to Soviet social insurance, which are discussed in this article.

"Measuring the Cost Benefit of Wellness Strategies" by Ronald M. Schwartz, Corporate Medical Director of Occidental Petroleum Corporation, Los Angeles, CA and Pierce L. Rollins, President of the Health Enhancement Resource Center, Los Angeles, *Business and Health*, Vol. 2, Number 10, October 1985, pp. 24-26.

The presentation of wellness programs at the worksite may result in significant financial savings to the company offering the program. There has been little except limited empirical evidence to support this claim. By taking medical insurance claims data on costs generated by the chronic illnesses addressed in wellness programs, placing dollar figures on the loss of productivity due to absenteeism, and determining the average short- and long-term disability payment costs for employees suffering these specific health problems, it is possible to postulate specific savings to a company under an ideal scenario. This would be a situation in which all employees followed completely the advice and instruction provided in each health enhancement activity offered. At Atlantic Richfield Company (ARCO), were such a course followed by all employees, potential savings to the company could well exceed $55 million annually. This article details these figures.

"The Merits of Hiring Disabled Persons", by Nina Hall, Thomas Mahnert and Elisa Lederer, International Center for the Disabled, New York, NY, *Business and Health*, February 1987, pp. 42-44.

This report from the International Council for the Disabled cites survey results on employment of disabled Americans. The survey indicated that approximately 12.4 million disabled people are not working. 8 million of these people want to work. The article goes on to explore myths about employment of disabled persons, value placed on their jobs by disabled persons, what employers can do to help and the potential payoffs of hiring disabled persons.

"Opening the Work Place to the Psychiatrically Disabled", by Barry F. Cohen, William A. Anthony and William A. Kennard, Center for Psychiatric Rehabilitation, Boston University, Boston, Massachusetts, *Business and Health*, Vol. 3, No. 4, March 1986, pp. 9-11.

The authors discuss the myths about the

ability or inability to work of psychiatrically disabled persons. They review three new approaches to rehabilitate the severely psychiatrically disabled: transitional employment, supported employment and supported learning.

"Pension Reform: Sharing the Burden", by Robert Holzmann, OECD Social Affairs, Manpower and Education Directorate, *The OECD Observer*, No. 138, January 1986, pp. 3-10.

A re-examination of public retirement provisions is underway in all OECD countries. The conventional reason for concern about pensions is the increasing share of available economic resources they absorb, but there are also questions about the financial soundness of these schemes, now and in the future. Connected with the financial issue, yet distinguishable from it, is the fact that society's view of the performance of pension systems is changing as new social preferences and needs assert themselves.

Despite the variety of retirement provisions in the OECD area, there is a striking similarity between countries in the rate of growth of pension expenditures, in the cause of this growth and the set of policy options envisaged. It is on these similarities that this article focuses.

"Physical Disability and Public Policy" by Gerben DeJong and Raymond Lifchez, *Scientific American*, Volume 248, Number 6, June 1983, pp. 40-49.

In the past 15 years or so there has been a major change in the policy of the U.S. with respect to citizens with disabilities. This article reviews the background of these issues, summarizes what is known about the dimensions of disability in the U.S., looks into the causes of the current stalemates in the implementation of the existing disability laws and tries to identify some of the ingredients needed to make the nation's disability policy a viable one in the face of current political and economic realities. It focuses in particular on one highly visible aspect of the problem, namely the removal of architectural barriers to the progress and well-being of people with disabilities.

"Psychiatric Case Management Offers Cost, Quality Control", by Alex R. Rodriguez, Vice President and Medical Director of Preferred Health Care Ltd., and Preferred Psych Care, Katonah, NY and John J. Maher, Manager of Self-Insurance Administration, CIBA-GEIGY Corporation, Ardsley, NY, *Business and Health*, Vol. 3, No. 4, March 1986, pp. 14-17.

Benefits managers and employers and insurers are virtually unanimous in their concern about the problems associated with psychiatric benefits, but they differ on the approach to dealing with this issue. The special circumstances and potential pitfalls of regulating and accounting for psychiatric services occur at a time when employers and insurers also are faced with having to contain the costs and maintain the quality of other medical and surgical services. Rodriguez and Maher report on CIBA-GEIGY's attempt to resolve these problems.

"Reforming the Swedish Social Security System" by Bjorn Sjoberg, Director of Legal Affairs, Ministry of Health and Social Affairs, Sweden, *International Labour Review*, 1985, Vol. 124, No. 1, pp. 61-72.

As the Swedish network of social security steadily expanded over the years, it also became more complicated. In 1975 a ministerial commission was appointed to review the entire system and make recommendations on how the various branches might be better coordinated and so merged as to form a general social insurance scheme. The author describes the work carried out over the past decade to make the system simpler, more coherent and more comprehensible to the public, the problems encountered in the process and some of the results achieved.

"Rethinking Disability Coverage" by Jane Stein, editor, *Business and Health*, April 1987, pp. 44-46.

Stein interviews Patricia M. Owens, Vice President of Disability Programs with the Paul Revere Insurance Group, Worcester, Mass. Although payers of disability insurance—both in the public and private sectors—have long been supporting a system that inadvertently encouraged injured, or physically or mentally impaired workers to spend the rest of their lives dependent on disability checks, Owens says that there are moves to change that. In her present position, she is concentrating on return-to-work incentives just as she did at the Social Security Administration where she was the Associate Commissioner for Disability.

"Roadblocks to Rehabilitation", by Eugenia S. Carpenter, President, Gini Associates, a health care consulting firm in Ann Arbor, Michigan, *Business and Health*, Vol. 3, No. 2, December 1985, pp. 22-24.

While the concept of rehabilitation has been connected with workers' compensation almost from the beginning, the extent of commitment to the actual program and services, and the resources invested, has been far overshadowed by the medical care and cash payments components of the system. Vocational rehabilitation includes such non-medical services as counseling, guidance, psychological and vocational testing, training and specialized job placement aimed at restoring injured workers to gainful employment. These issues are discussed along with possible solutions.

"Setting Benchmarks for Cost-Effective Care", by Dale Shaller, Executive Vice President, Center for Policy Studies, Minneapolis, MN and Susan Gunderson, Administrator of Health Care Studies Unit, Mayo Clinic, Rochester, MN, *Business and Health*, Vol. 3, No. 10, October 1986, pp. 28-32.

In 1985, researchers at the Mayo Clinic in Rochester, Minn., and the Center for Policy Studies in Minneapolis, conducted a study to develop and test one set of comparative benchmarks, or reference points, for assessing corporate hospital utilization and expenditures. The study suggests that such benchmarks derived from one or more provider groups of acknowledged quality can be a useful comparative test for helping purchasers identify potential cost and utilization problems and more effectively target health care management efforts.

"Social Security News: Canada", *International Social Security Review*, 1/85, International Social Security Association, Geneva, pp. 75-78.

This article presents news on the Canadian reform of the pensions systems, new legislation on sickness insurance and improvements to benefits provided under the Quebec Pension Plan.

"Sociology and social security: A fresh approach", by Roland Sigg, General Secretariat of the ISSA, *International Social Security Review*, 4/85, International Social Security Association, Geneva, pp. 3-19.

This article proposes to identify the elements of the sociological perspective that are of most interest to social security practitioners, in order to show that sociology can make a valuable contribution to the development of social security in parallel with—and as a complement to—other academic disciplines, such as economics, demography and jurisprudence.

"Thuishulpcentrale: A Dutch Model for Practical Family Assistance", by Hilda P. Versluys, Assistant Professor of Occupational Therapy at Sargent College of Allied Health Professions, Boston University, *Rehabilitation Literature*, Vol. 47, No. 3-4, March-April 1986, pp. 50-51.

This article is excerpted from a 1983 World Rehabilitation Fund International Exchange of Experts Report. The report was based on an investigation in The Netherlands of the Dutch 'interweave' of enabling organizations concerned with the welfare of the family that includes a child with a disability. Specifically, those organizations performing advocacy, communication, and liaison functions and assist the family not only in caring for the child but in the rehabilitation, education, and development of that child were considered. This includes a concern for independence in living, integration into the community, and the quality of family and social life. The article reviews the documented needs of such families in the United States, describes a Dutch model for practical support and assistance to the family, the influence of the Dutch parents' initiative movement and support groups, and the role of volunteerism in The Netherlands.

"Vocational Rehabilitation: Lessons for Employers" by John A. Gardner, senior economics, Workers' Compensation Research Institute, Cambridge, Mass., *Business and Health*, March 1987, pp. 20-24.

Using data from the New York State Workers' Compensation Board for cases closed between 1981 and 1983, the Workers' Compensation Research Institute recently explored and analyzed relationships among injured workers, vocational rehabilitation program features and outcomes. The data suggest that important differences exist between public and private programs, and that managers should be aware of them since they affect program costs and outcomes.

"Xerox's Style of Disability Management", by Jane Stein, Editor, *Business and Health*, Vol. 3, No. 1, November 1985, pp. 47-49.

Disability management at Xerox Corporation is run so well that last year it cost the company $9 million less than actuaries had estimated in long-term disability benefits alone. This article interviews Donald R. Koerner, Internist and Manager of the company's disability services on the reasons for Xerox's high degree of success.

APPENDIX C

INTERNATIONAL EXCHANGE OF EXPERTS AND INFORMATION IN REHABILITATION

The following published monographs are still available in book form from WRF.

1979-1984 MONOGRAPHS

#14 Childhood Disability in the Family.
Elizabeth Zucman, M.D. France

#15 A National Transport System for Severely Disabled Persons—A Swedish Model
Birger Roos, National Transport Board for the Handicapped, Sweden.

#20 Adapting The Work Place for People with Disabilities: Ideas from Sweden
Gerd Elmfeldt

#21 Rehabilitation in Australia: U.S. Observation.
(Contributions from Several WRF Fellows.)

#23 Methods of Improving Verbal and Psychological Development in Children with Cerebral Palsy in the Soviet Union.
Robert Silverman—Translator.

#24 Language Rehabilitation After Stroke: A Linguistic Model.
Gunther Peuser, Federal Republic of Germany

#25 Societal Provision for the Long-Term Needs of the Mentally and Physically Disabled in Britain and in Sweden Relative to Decision-Making in Newborn Intensive Care Units.
Ernie W.D. Young, U.S. WRF Fellow.

#27 Independent Living and Disability Policy in the Netherlands: Three Models of Residential Care and Independent Living.
Gerben DeJong—U.S. WRF Fellow.

#28 The Future of Work and Disabled Persons: The View from Great Britain.
Paul Cornes, Univeristy of Edinburgh.

#30 Employer Initiatives in the Employment or Re-Employment of People with Disabilities: Views from Abroad, with Introduction by Sheila Akabas

#31 The More We Do Together: Adapting the Environment for Children with Disabilities. (Nordic Committee on Disability)

We regret that several monographs in the series are no longer available, nor can we predict how long the 1979-1984 monographs will be available for distribution.

1985-87 MONOGRAPHS

#32 Life Transitions of Learning Disabled Adults: Perspectives from Several Countries.
K. Garnett, P. Gerber—Editors.

#33 Bridges from School to Working Life for Handicapped Youth: The View from Australia.
Trevor Parmenter—MacQuarie University

#34 Independent Living and Attendant Care in Sweden: A Consumer Perspective.
Adolph Ratzka

#35 Evaluation and Information in the Field of Technical Aids for Disabled Persons: A European Perspective.
A. Pedotti and R. Andrich, Eds. Italy

#36 An International Perspective on Community Services and Rehabilitation for Persons with Chronic Mental Illness
Contributions from the U.K., Canada, Australia and Sweden

#37 Interactive Robotic Aids—One Option for Independent Living: An International Perspective
Contributions from the Netherlands, the U.K. and Canada

#39 Family Supports for Families with a Disabled Member
Contributions from several countries.

#40 New Developments in Worker Rehabilitation—"Workcare" in Australia
Andrew Remenyi, Hal Swerissen, Shane A. Thomas—Editors

#41 Social Security Disability Programs: An International Perspective
Contributions from several countries.

#WRF/HRC The Changing Nature of Work, Society and Disability: The Impact on Rehabilitation Policy
David Vandergoot, Diane Woods—Editors

For information on how to order monographs and fellowship reports, please write to WRF IEEIR for a brochure.

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